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American Medical Association

AUGUST 28, 1954

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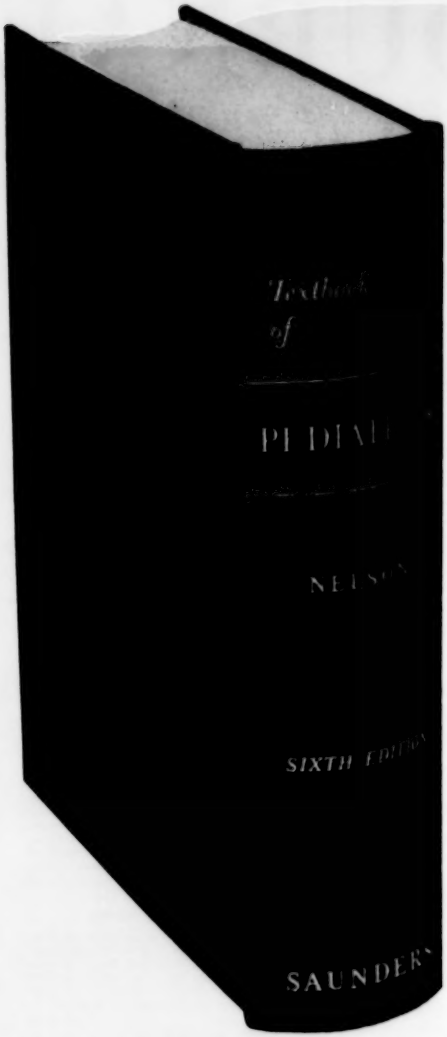

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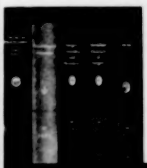

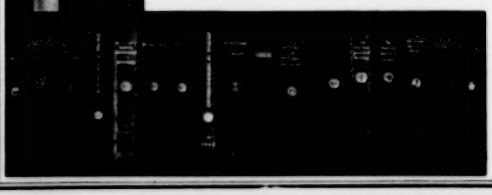

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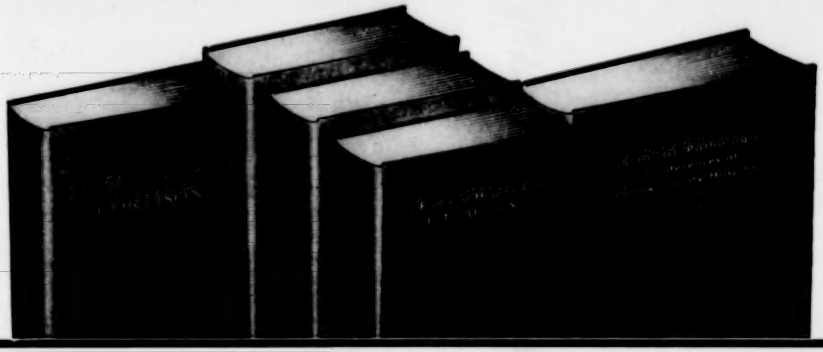

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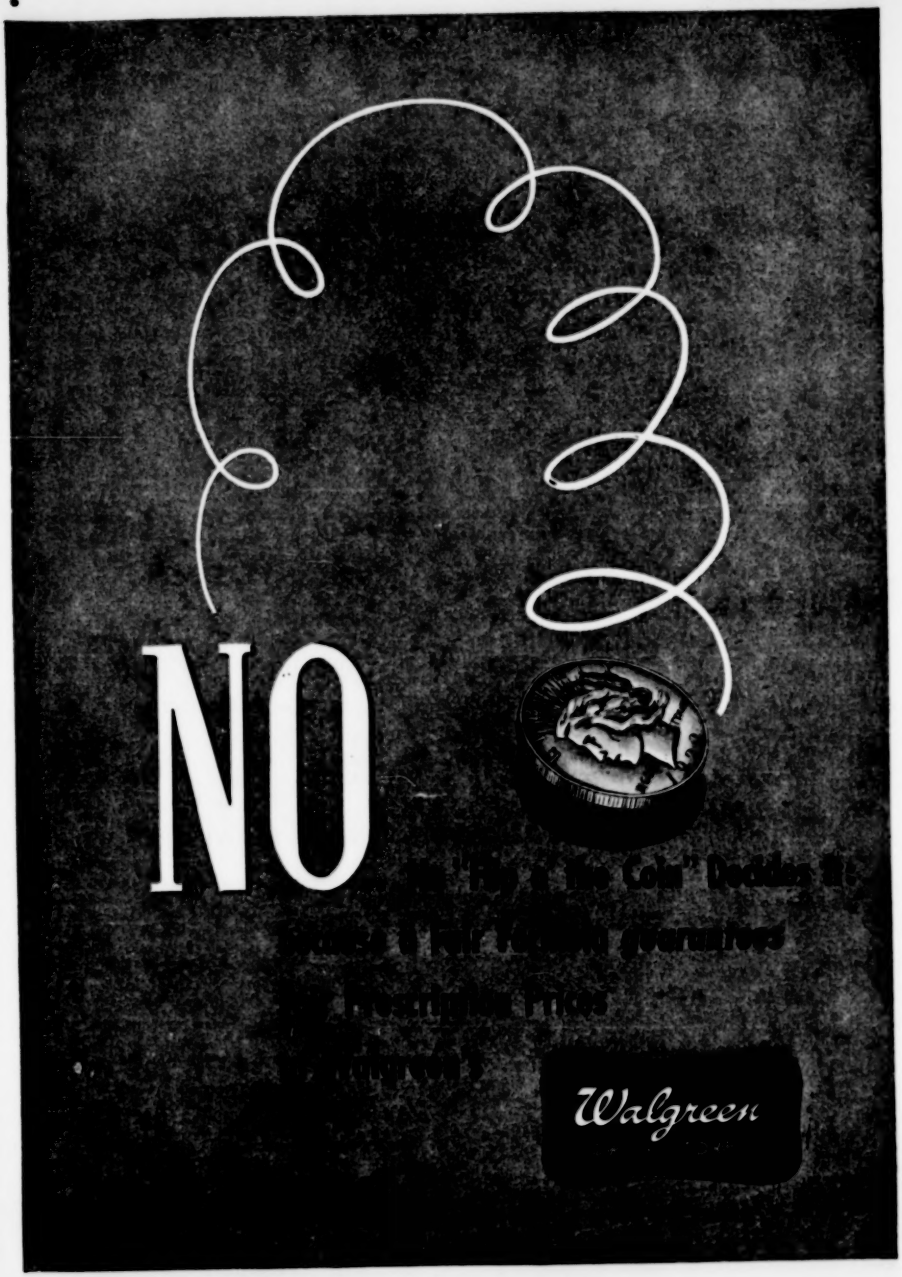

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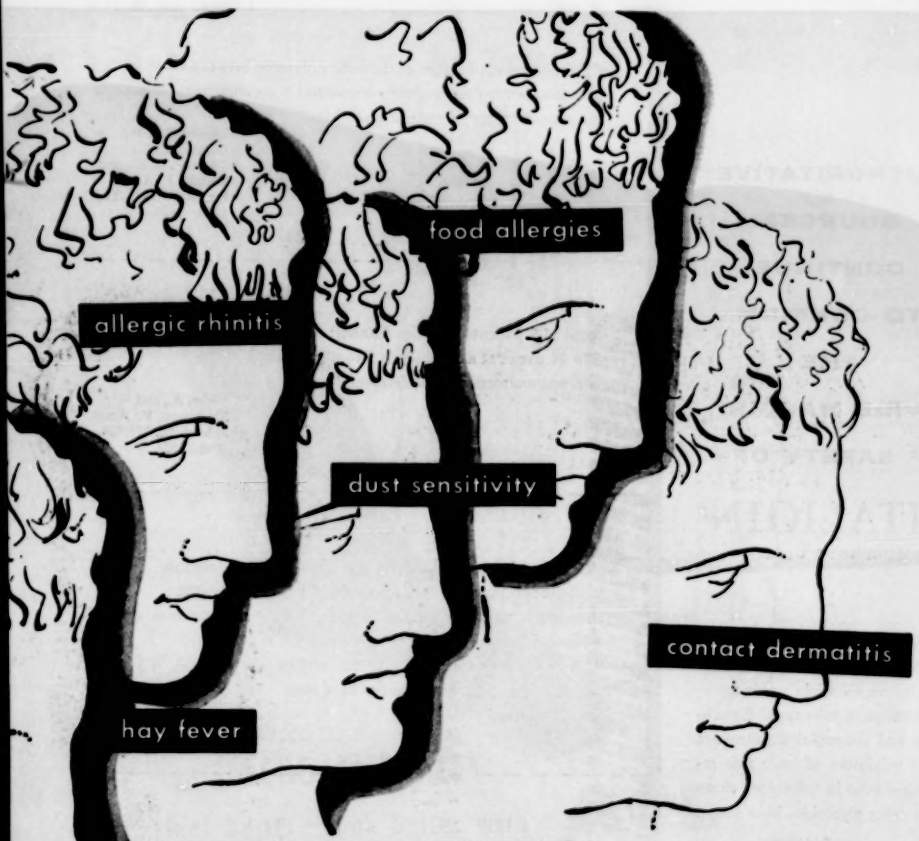

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Dimitroff, S. P.; Griffith, G. C.; Thorner, M. C., and Walker, J.: Annals of Int. M. *39*:1189 (Dec.) 1953.

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Weiss, A., and Steigmann, F.: Amer. J. Med. Sc. *227*:188 (Feb.) 1954.

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Marriott, H. J. L.: Editorial, Annals of Int. M. *40*:820 (April) 1954.

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Batterman, R.C.; DeGraff, A.C., and Rose, O.A.: Circulation *5*:201 (Feb.) 1952.

"Other desirable properties of amorphous gitalin [Gitaligin] include its rate of dissipation, uniformity in clinical potency, and predictability of dosage."

Batterman, R.C.; DeGraff, A.C.; Gutner, L.B.; Rose, O.A., and Lhowe, J.: Amer. Heart J. *42*:292 (Aug.) 1951.

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WASHINGTON NEWS

SOCIAL SECURITY

By a voice vote, the Senate approved the extension of social security coverage to another 6,500,000 persons. The measure was then sent to conference in order to reconcile the differences between the Senate and House versions. On the question of inclusion of physicians under Old Age and Survivors Insurance, the Senate agreed with the House that physicians should not be brought into the program. Similarly, the Senate concurred with the House version on the waiving of OASI premiums for workers found to be disabled under which medical examinations under federal-state supervision will be required if a worker is to be given credit for the period of disability. The American Medical Association has advocated instead that pension rates be based on the best 10 income years of a worker, a procedure that would eliminate medical examinations in all but a few instances.

During the late evening debate and final action on the bill, several senators raised the question of bringing professional persons under OASI. Chairman Eugene Millikin of the Senate Finance Committee commented that his committee was willing to bring any professional group into the program if there were clearly demonstrable proof that its members want to be included. He added: "I think I am voicing the unanimous opinion, or almost unanimous opinion, of the committee when I state that we should not bring in any group unless that group strongly wants it."

NATIONAL FUND FOR MEDICAL EDUCATION

Congress has now granted a federal charter, an unusual recognition, to the National Fund for Medical Education. The legislation was sponsored in the House by Rep. Richard Poff (R., Va.), and the Senate bill bore the name of the late Senator Robert A. Taft. To retain Senator Taft's name on the bill, the Senate measure was amended to include the language of a bill introduced in the House by Mr. Poff. The effect of this language was to bring the bill into line with suggestions made by the American Medical Association.

Under the new law the corporation's membership consists of a large group of leaders in business, government, and the professions, all of whom are named. The board of directors will be made up of the present board of the foundation, and, in addition, will include Drs. Donald C. Balfour, Rochester, Minn.; Louis H. Bauer, Hempstead, N. Y.; Howard A. Rusk, New York City; and Harvey B. Stone, Baltimore. The charter also provides that at all future times at least four members of the board must be members of the medical profession. Under the federal charter, the purposes of the corporation are described as follows: "Sec. 3. The purposes of the corporation shall be to raise from private sources, disperse and administer funds for medical education and in connection therewith to take other appropriate action to promote and foster the following objectives: (1) The interpretation of the needs of medical education to the American public; (2) The encouragement of the growth, development and advancement of constantly improving standards and methods in the education and training of all medical manpower in the Nation; and (3) The preservation of academic freedom in the institutions of medical education."

From the Washington Office of the American Medical Association.

HOSPITAL CONSTRUCTION

The administration's new program for expanding Hill-Burton hospital construction is getting 23 million dollars for the next year. The President had asked for 35 million dollars, but Congress trimmed this somewhat on the basis that it already had appropriated 75 million for the regular Hill-Burton program. The additional money is earmarked as follows: 6,500,000 for hospitals for the chronically ill, 6,500,000 for diagnostic-treatment centers, 4 million for nursing homes, 4 million for rehabilitation centers, and 2 million for state studies of the need for additional construction. Final congressional action came in a supplemental appropriation bill that added nearly 50 million dollars to the Department of Health, Education, and Welfare's regular budget of $1,663,413,761. Other supplemental health items include 4 million dollars for the expanded vocational rehabilitation program conducted on a federal-state basis, 5 million for the expanded social security program, and one million for civil defense research.

ORAL PRESCRIPTION FOR DRUGS

The Senate Finance Committee, in favorably reporting a bill permitting oral prescription of drugs having little or no addiction potential, notes that the measure gives statutory recognition to the need for telephone dispensing of certain narcotic drugs. The committee observed: "There are many occasions where the health of the patient may be better served if the physician is at liberty to telephone a prescription calling for narcotic drugs which have little or no addiction liability and thus implement prompt treatment of the patient. The oral prescription procedure, together with the attendant safeguards against possible abuse . . ., provides a practical way to handle a situation which has been troublesome to both physicians and pharmacists for many years." The committee called the Senate's attention to the fact the bill is endorsed by the American Medical Association, independent retail druggists, and the Federal Bureau of Narcotics.

CURRENT QUOTATIONS

President Eisenhower, on signing the tax revision bill into law: "This bill which today becomes law is the excellent result of cooperative efforts by the Department of the Treasury to give our tax code its first complete revision in 75 years. It is a good law. It will benefit all Americans . . . . People with large medical expenses will now be able to deduct from their income all such expenses which exceed 3% (rather than 5%) of their incomes, and the maximum amounts deductible will be twice as large as they were in the past." . . . Secretary Hobby, in talking with newsmen: "We can't complain about what happened in legislation. . . . The only setback was health reinsurance being recommitted. It was a new and novel idea, and many new and novel ideas don't get by the first time. . . . I am not discouraged. Maybe we can write a better bill. Maybe then we can be more specific." (The bill, opposed by the A. M. A., was recommitted to the House Interstate and Foreign

Commerce Committee, killing it for this year) . . . Major Gen. Dan C. Ogle, in his first address since becoming surgeon general of the Air Force: "A reduction of five points in the medical noneffective rate would save sufficient military manpower to man one war-strength, fully supported infantry division or approximately five medium bombardment wings. . . . Translated into terms of national economy and applied to a medical factor, such a reduction in noneffective rates would save enough in one year to build up and equip 30 beautiful 300-bed hospitals. . . ."

HEALTH OF INDIANS

According to Glenn I. Emmons, Commissioner of Indian Affairs, the health conditions prevailing today on the reservations are remarkably similar to those found throughout the United States rather generally 50 or even 75 years ago. "In other words," the commissioner explained, "many of these Indian areas have been almost like islands and have been practically untouched by the great advances in public health protection which have taken place throughout the country during recent decades." These remarks were delivered by the commissioner before a seminar at the Intertribal Indian Ceremonial at Gallup, N. Mex.

The legislation transferring Indian health affairs to the United States Public Health Service is expected to help greatly in alleviating these conditions. Largely because of the great difficulty that the Indian Bureau has long had in recruiting and holding competent professional health personnel, Commissioner Emmons personally believes that this transfer will prove beneficial to the Indian people. After the transfer has been effected, "proper staffing of the Indian hospitals will be easier to maintain and more fully adequate service for patients will be provided," he said. Added advantages will accrue from the great research facilities of the Public Health Service and "the tremendous accumulation of technical knowledge which that agency has acquired over a period of many years." In giving an up-to-date progress report on medical work done over the past several months in preparation for the change, Mr. Emmons said that his department had been "building up the staff of professional sanitarians, health educators and other public health specialists both at area offices and at agency headquarters." As a means of coordinating personnel, young Indians are being trained as sanitarian aides to work along with the professionals. Twenty of these young men recently completed a special orientation course at the Phoenix Medical Center and are now on duty at the various reservations. "The primary job of all these specialists and their aides will be to bring the benefits of modern sanitation and personal hygiene directly into Indian homes and communities," Mr. Emmons stated.

To point out the practicality of the program, Mr. Emmons described some of the procedures to be followed: "Meetings and demonstrations will be held right out on the reservations and Indian families will be given first-hand advice and guidance on how to build and maintain safe water supplies wherever feasible in these semi-arid areas, how to control insect breeding places, and many other phases of personal and community health protection." The work will be carried forward "as far as possible" before next July and then turned over to the PHS. Expressing confidence in the effective and vigorous continuance of the program after that time, Mr. Emmons stated that the ultimate goal is "to bring the Indian disease and death rates down to the levels which prevail for the general population and to eliminate the reservoirs of infection which unfortunately exist in so many Indian communities today."

MEDICAL RESEARCH GRANTS

Medical researchers received $14,685,671 when the National Institutes of Health recently awarded 1,442 grants for study of the major diseases afflicting Americans today. The NIH, research arm of the Public Health Service, Department of Health, Education, and Welfare, made the awards to scientists in 335 American research institutions. One-third of the grants, 459 totaling $4,568,073, were for new projects. The National Cancer Institute gave out the largest single number of these: 92 paying $981,074. The remaining two-thirds of the awards, 983 for $10,117,598, will support continuing research. The National Heart Institute granted the largest number of such awards: 213 totalling $2,283,370. Effects of hormones on hardening of the arteries, edema mechanisms occurring in heart failure, and effects of temperature and humidity on the circulatory system are typical of National Heart Institute projects.

The announced grants represent about 60% of the PHS medical research budget appropriated by Congress for the current fiscal year. Each of the national institutes distributed the following amounts for both new and continuing research: National Institute of Arthritis and Metabolic Diseases, 212 grants for $2,004,534; National Institute of Neurological Diseases and Blindness, 195 grants for $1,798,267; National Cancer Institute, 287 grants for $3,163,469; National Institute of Dental Research, 23 grants for $197,165; National Microbiological Institute, 141 grants for $1,315,483; National Heart Institute, 294 grants for $3,196,308; National Institute of Mental Health, 67 grants for $972,571; and Division of Research Grants (for health and medical categories not covered by preceding institutes), 223 grants for $1,177,874.

MISCELLANY

George P. Larrick, a career officer in the Food and Drug Administration, climaxed more than 30 years of service with the agency when he was sworn in Aug. 12 as Commissioner of Foods and Drugs. The oath was administered to Mr. Larrick, who succeeds Dr. Charles W. Crawford, by Parke Banta, general counsel of the Department of Health, Education, and Welfare, in the presence of Secretary Oveta Culp Hobby. . . . Three of the bills enacted in the closing days of the Congress will: (1) permit shipping companies to pay overtime to U. S. Public Health Service quarantine officers for out-of-hours inspection of incoming vessels (under the present system, with inspections conducted only between 6 a. m., and 6 p. m., 41% of the vessels arriving in New York were held up pending quarantine inspections); (2) boost from $500 to $700 the amount of federal aid paid annually to states for each veteran hospitalized in a state institution; and (3) authorize the President to designate Oct. 11 to 16 as "National Nurse Week." . . . Foreign Operations Administration, under a contract worked out with the American College of Surgeons, will finance U. S. study trips for 100 European physicians varying from six weeks to three years. Selection will be by local medical committees, and the physicians' own countries will pay for transportation. The College of Surgeons will be in overall charge.

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PARITY AND CONCEPTION CONTROL

A report covering a total of 425 patient years of exposure

A meticulous study[1] of 325 patients using jelly alone as a contraceptive measure notes a markedly higher degree of effectiveness for this technic "among patients of lower parity."

Apparently this significant conclusion can be attributed mainly to the anatomic factor. The less relaxed vagina in the lower parity group permits a more successful confinement of the jelly to the region of the external os.

For a period of three years, Guttmacher and associates[1] studied the efficacy of jelly-alone technic for contraception among multiparas and patients of lower parity. Although the method achieved marked success among all groups, a few unplanned pregnancies did occur. It was possible to categorize all of these unplanned pregnancies into either "method failures" or "patient failures." Patient failures were those wherein patients readily admitted occasional or frequent omission of the use of the jelly before intercourse. Method failures were attributed only to those cases where patients averred a complete adherence to the use of the jelly.

With 325 patients using the jelly-alone [RAMSES VAGINAL JELLY] technic for periods ranging from 3 months to 3 years, a computation showed that there was a total of 425 exposure years involved. The total unplanned pregnancy rate averaged only 16.7 per 100 patient years of exposure.

When method failures only were computed, the unplanned pregnancy rate dropped to 10.82 per 100 years of exposure.

1. Finkelstein, R.; Guttmacher, A., and Goldberg, R.: Am. J. Obst. & Gynec. 63:664, Mar., 1952.

Conception control in 325 patients using RAMSES Vaginal Jelly for 3 months to 3 years[1]

On the basis of observations, the conclusion is valid that while RAMSES VAGINAL JELLY is markedly effective as a jelly-alone technic, the method is "one of choice" in patients of lower parity and, of course, among the nulliparous.

Because parity, motivation, and patient intelligence all play a major part in the success of a contraceptive technic, the final basis for selection of the contraceptive method must rest with the physician whose judgment is predicated on a thorough evaluation covering all of these factors.

When in the judgment of the physician, parity, anatomic factors, or motivation indicate the use of the diaphragm-and-jelly method of contraception, the RAMSES® TUK-A-WAY® Kit is recommended. The RAMSES® diaphragm is flexible and cushioned—provides an optimum barrier and utmost comfort. In combination with RAMSES jelly it offers a reliable contraceptive technic.

Physicians may now obtain a complimentary package of RAMSES VAGINAL JELLY*. Requests on your prescription blank should be mailed to Dept. JA1, Julius Schmid, Inc., 423 West 55th Street, New York 19, N. Y.

*Active agent, dodecaethyleneglycol monolaurate 5%, in a base of long-lasting barrier effectiveness.

JULIUS SCHMID, INC. *gynecological division*
423 West 55th Street, New York, 19, N. Y.

SOCIETY	PRESIDENT	SECRETARY	MEETING
American			
Radium Society	John E. Wirth, Pasadena, Calif.	Robert E. Fricke, 102 Second Ave., Rochester, Minn.	Washington, D. C., April 21-23
Rheumatism Assn.	Edward W. Boland, Los Angeles 5	W. H. Kammerer, 23 E. 61st St., New York 21	Atlantic City, N. J., June 1955
Roentgen Ray Society	Harry Weber, Rochester, Minn.	Barton R. Young, Germantown Hosp., Philadelphia 44	Washington, D. C., Sept. 21-24
School Health Assn.	H. F. Kilander, East Orange, N. J.	A. O. DeWeese, 515 E. Main St., Kent, Ohio	Buffalo, N. Y., Nov. 1954
Society for Clinical Investigation	Robert H. Williams, Seattle	J. D. Meyers, 622 West 168th St., New York 32	Atlantic City, N. J., May 2
Society for Experimental Pathology	Russell L. Holman, New Orleans	Cyrus C. Erickson, 874 Union Ave., Memphis 3, Tenn.	San Francisco, Apr. 10-16
Society for Pharm. & Ex. Ther.	Charles M. Gruber, Loma Linda, Calif.	Carl C. Pfeiffer, 1853 W. Polk St., Chicago 12	San Francisco, Apr. 10-16
Society for the Study of Sterility	John O. Hassan, San Francisco	H. H. Thomas, 929 S. 19th St., Birmingham, Ala.	Atlantic City, N. J., June 1955
Society of Anesthesiologists	Ralph T. Knight, Minneapolis	J. E. Remlinger Jr., 185 W. Randolph St., Chicago 1	Cincinnati, Oct. 25-30
Society of Biological Chemists	C. G. King, New York	Philip Handler, Duke University, Durham, N. C.	San Francisco, April 1955
Society of Clinical Pathologists	John R. Schenken, Omaha	C. G. Culbertson, 1040 W. Michigan St., Indianapolis 6	Washington, D. C., Sept. 6
Society of Maxillofacial Surgeons	Clifford L. Klein, Cleveland	John A. Drummond, 1414 Drummond St., Montreal, Can.	Louisville, Ky., May 1955
Society of Tropical Medicine & Hygiene	Frederick J. Brady, Washington 25, D. C.	John E. Larsh Jr., Univ. of N. Car., Chapel Hill, N. C.	Memphis, Tenn., Nov. 4-6
Surgical Assn.	John H. Gibbon, Jr., Philadelphia	B. Kennedy Gilchrist, 59 East Madison St., Chicago 2	Philadelphia, April 27-29
Therapeutic Society	William B. Bawls, New York	O. B. Hunter Jr., 915 19th St. N.W., Washington, D. C.	St. Louis, Nov. 4-7, 1954
Trudeau Society	John D. Steele, Milwaukee, Wis.	William G. Childress, 1720 Broadway, New York 19	Milwaukee, Wis., May 23-27
Urological Assn.	W. Joseph McMartin, Omaha 2, Neb.	C. H. de7 Shivers, 121 South Illinois Ave., Atlantic City	Los Angeles, May 16-19
Venereal Disease Assn.	L. W. Shaffer, Grosse Pt. Farms 36, Mich	John C. Hume, 615 N. Wolfe St., Baltimore 5	
Veterinary Medical Assn.	J. A. McCallan, Washington, D. C.	J. G. Harlenbergh, 600 S. Michigan Ave., Chicago 5	
Assn. for Research in Nervous & Ment. Dis.	Rustin McIntosh, New York 32	Clarence C. Hare, 710 W. 168th St., New York 32	New York, 1954
Assn. for Research in Ophthalmology	P. Robb McDonald, Philadelphia	James H. Allen, 1430 Tulane Ave., New Orleans 12	
Assn. of American Medical Colleges	Stanley Dorst, Cincinnati	Dean F. Smiley, 182 N. Wabash Ave., Chicago	French Lick, Ind., Oct. 17-20
Assn. of American Physicians	Robert F. Loeb, New York 32	W. Barry Wood Jr., 600 S. Kingshighway Blvd., St. Louis	Atlantic City, N. J., May 3-4
Assn. of Life Ins. Med. Directors of Am.	Richard C. Montgomery, Toronto, Canada	Henry R. Kirkland, P. O. Box 594, Newark 1, N. J.	Toronto, Canada, Oct. 13-15
Assn. of Medical Illustrators	Mrs. Muriel McLatchie Miller, Boston	Miss Evelyn J. Erickson, 1512 St. Antoine St., Detroit 26	
Assn. of Military Surgeons of U. S.	Leonard A. Scheele, Washington, D. C.	R. E. Bitner, Armed Forces Inst. of Path., Washington 25	Washington, D. C., Nov. 29-Dec. 1
Assn. of State & Territorial Health Officers	Harold M. Erickson, Portland 1, Oregon	Franklin D. Yoder, State Board of Health, Cheyenne, Wyo.	Washington, D. C., Dec. 6-10
Biological Photographic Assn.	Dr. Warren Sturgis, New York	Miss Jane H. Waters, 523 W. 57th St., New York 19	Atlantic City, N. J., 1954
Central Assn. of Ob. & Gyn.	Harold C. Mack, Detroit	Harold L. Gainey, 4635 Wyandotte St., Kansas City, Mo.	St. Louis, Oct. 6-9
Central Neuropsychiatric Assn.	Mabel Maxton, Madison, Wis.	Harold Nordt, Box 1012, North Blvd., Galveston, Texas	Detroit, Oct. 1954
Central Society for Clinical Research	Jerome W. Conn, Ann Arbor, Mich.	Robert H. Ebert, 950 East 59th St., Chicago 37	Chicago, Oct. 29-30
Central Surgical Assn.	Leon J. Leahy, Buffalo, N. Y.	Robert M. Zollinger, University Hospital, Columbus 10, O.	Chicago, Feb. 17-19
Clinical Orthopaedic Society	C. Leslie Mitchell, Detroit	John H. Moe, 825 Delaware Ave., Minneapolis	Chicago, Oct. 7-9
College of American Pathologists	David A. Wood, San Francisco	Arthur H. Dearing, 202 N. Wabash Ave., Chicago 1	Washington, D. C., Sept. 6
Gerontological Society	Anton J. Carlson, Chicago	Nathan W. Shock, Baltimore City Hospitals, Baltimore 24	Gainesville, Fla., Dec. 28-30
Industrial Medical Association	Robert Collier Page, New York	H. Kelley Gardiner, Inland Steel Co., East Chicago, Ind.	Buffalo, N. Y., April 25-29
Interstate Postgrad. Med. Assn. of N. A.	Jonathan C. Meakins, Montreal, Canada	Erwin R. Schmidt, 1300 University Ave., Madison 6, Wis.	Minneapolis, Nov. 1-4
Medical Library Assn.	Miss Wilma Trosel, Chicago	Miss Esther Jolkins, Rockefeller Institute, New York 21	Milwaukee, May 17-20
National Gastroenterological Assn.	Sigurd W. Johnson, Passaic, N. J.	A. Xerxes Rosen, 23 West 60th St., New York 23	Washington, D. C., Oct. 25-30
National Medical Assn.	A. Porter Davis, Kansas City, Kan.	John T. Givens, 1104 Church St., Norfolk 10, Va.	
National Multiple Sclerosis Society	Mr. Edward L. Wallgren, New York	Miss Sylvia Lawry, 270 Park Ave., New York 17	New York, March 1955
National Proctologic Assn.	James F. Elder, Sharon, Pa.	George E. Mueller, 59 East Madison St., Chicago 2	Chicago, Oct. 7-9
National Tuberculosis Assn.	John H. Stanley, Cincinnati	Mrs. Morrell DeReign, 1790 Broadway, New York 19	Milwaukee, May 23-27
Neurosurgical Society of America	C. D. Hoerner, Memphis, Tenn.	Lester A. Mount, 760 W. 168th St., New York 32	
Radiological Society of North America	Eugene P. Pendergrass, Philadelphia	D. S. Childs, 713 E. Genesee St., Syracuse 2, N. Y.	Los Angeles, Dec. 5-10
Society for Investigative Dermatology	Clarence S. Livingood, Detroit	Herman Beerman, 255 S. 17th St., Philadelphia 3	Atlantic City, N. J., June 4-5
Society for Pediatric Research	Charles D. Aring, Boston	Sydney S. Gellis, 330 Brookline Ave., Boston 15	Montreal, Canada, June 1955
Society for Vascular Surgery	Robert B. Linton, Brookline 46, Mass.	George D. Lilly, 25 S.E. Second Ave., Miami 32, Fla.	Atlantic City, N. J., June 5
Society of American Bacteriologists	C. B. Van Neil, Pacific Grove, Calif.	J. H. Bailey, Sterling-Winthrop Res. Inst., Rensselaer, N. Y.	New York, May 1955
Society of Biological Psychiatry	Harold E. Himwich, Galesburg, Ill.	George N. Thompson, 1910 Wilshire Blvd., Los Angeles 57	Chicago, 1955
Society of Clinical Surgery	John B. Gibbon Jr., Philadelphia	Champ Lyons, 620 S. 20th St., Birmingham 5, Ala.	Denver, October 1954
Society of Neurological Surgeons	James Gardner, Cleveland	Bronson S. Ray, 535 S. 68th St., New York 21	Boston, May 1955
Society of University Surgeons	Earle B. Mahoney, Rochester, N. Y.	C. Rollins Hanlon, 1325 S. Grand Blvd., St. Louis	Houston, Texas, Feb. 9-12
Southeastern Surgical Congress	J. Duffy Hancock, Louisville, Ky.	B. T. Beasley, 45 Edgewood Ave. S.E., Atlanta 3, Ga.	Atlanta, Ga., Mar. 7-10
Southern Medical Assn.	Alfonso McMillan, St. Louis	Mr. C. P. Loran, Empire Bldg., Birmingham 3, Ala.	Atlantic City, N.J., 1954
Southern Surgical Assn.	John C. Burch, Nashville, Tenn.	George G. Finney, 2947 St. Paul St., Baltimore, Md.	Hollywood, Fla., Dec. 7-9
Southwestern Medical Assn.	Willard W. Schuessler, El Paso, Texas	Orbie C. Stapp, 800 Montana St., El Paso, Texas	El Paso, Texas, Nov. 17-19
Southwestern Surgical Congress	Philip B. Price, Salt Lake City	C. B. Rountree, 1227 Classen Drive, Oklahoma City 3	Oklahoma City, Sept. 20-22
Student American Medical Assn.	Mr. J. A. Oates Jr., Winston-Salem, N.C.	Mr. Russell F. Staudacher, 510 N. Dearborn St., Chicago 10	Chicago, May 6-8
The Endocrine Society	Allan T. Kenyon, Chicago	H. H. Turner, 1200 N. Walker St., Oklahoma City	Atlantic City, N. J., June 2-4
U. S. Chapter, International Coll. of Surgeons	William R. Lovelace, Albuquerque, N. M.	Karl Meyer, 1516 Lake Shore Dr., Chicago	Chicago, Sept. 7-10
Western Industrial Medical Assn.	Homer S. Elmquist, Los Angeles	Edward J. Zalk, 740 S. Olive St., Los Angeles 14	San Francisco, 1955
Western Orthopedic Assn.	Leonard B. Barnard, Oakland, Calif.	Harry H. Walker, 354 Hobart St., Oakland 12, Calif.	Oakland, Calif., Oct. 1954
Western Society of Electro-Encephalography	John R. Green, Phoenix, Ariz.	S. N. Berens, 902 Boren Ave., Seattle	Phoenix, Ariz., 1955
Western Surgical Assn.	Herbert B. Davis, Omaha	Michael Mason, 154 E. Erie St., Chicago	Colorado Springs, Colo., Dec. 2-4
Woman's Auxiliary to the Am. Med. Assn.	Mrs. George Turner, El Paso, Texas	Miss Margaret Wolfe, 535 N. Dearborn St., Chicago 10	Atlantic City, N. J., June 6-10
World Medical Assn.	L. A. Hulst, Utrecht, Netherlands	Louis H. Bauer, 345 E. 46th St., New York 17	Rome, Italy, Sept. 26-Oct. 2

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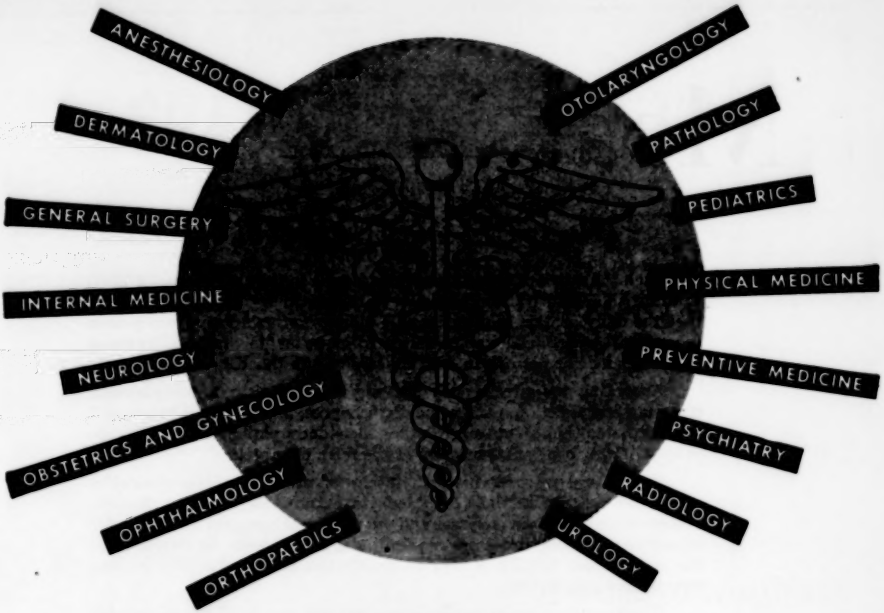

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Meat...

in Geriatric Nutrition

Although the nutrient needs for optimal health in the aged are not known to differ significantly from those in younger adults,[1] it has been shown that the daily protein requirements in elderly patients vary from person to person. Ascertained values range from below to above allowances recommended for persons in earlier years of adulthood.[2]

According to criteria such as "physical activity, gastrointestinal structure and function, pathologic disturbances, and chemical balances," it is suggested that an optimal diet for the elderly patient should provide at least 20 per cent of its calories in the form of protein.[3]

For several reasons this high intake of protein appears desirable. Decreased activity in the aged tends to induce loss of tissue protein. Preservation of protein enzymes and of endocrinal harmony necessary for supporting anabolic processes requires adequate protein nutrition. Also, the aged person usually is able to handle the end products of protein metabolism satisfactorily.

Generous amounts of tender lean meat can go a long way in supplying the needs of the aged for top quality protein. From 25 to 30 per cent or more of cooked lean meat is protein. Other valuable contributions include the B group of vitamins and essential minerals, especially iron, phosphorus, and potassium. The easy and almost complete digestibility and the palate appeal of meat constitute physiologic values important in the nutrition of the geriatric patient.

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1. Sebrell, W. H. Jr., and Hundley, J. M.: Malnutrition, in Stieglitz, E. J.: Geriatric Medicine, Medical Care of Later Maturity, ed. 3, Philadelphia, J. B. Lippincott Company, 1954, chap. 13.

2. Ohlson, M. A.; Roberts, P. H.; Joseph, S. A., and Nelson, P. M.: Nutrition and Dietary Habits of Aging Women, Am. J. Pub. Health *40*:1101 (Sept.) 1950.

Albanese, A. A.; Higgons, R. A.; Vestal, B.; Stephanson, L., and Malsch, M.: Protein Requirements of Old Age, Geriatrics *7*:109 (Mar.-Apr.) 1952.

Roberts, P. H.; Kerr, C. H., and Ohlson, M. A.; Nutritional Status of Older Women; Nitrogen, Calcium, Phosphorus Retentions of 9 Women, J. Am. Dietet. A. *24*:292 (Apr.) 1948.

Kountz, W. B.; Hofstatter, L., and Ackermann, P.: Nitrogen Balance Studies in Elderly People, Geriatrics *2*:173 (May-June) 1947.

Kountz, W. B.; Hofstatter, L., and Ackermann, P. G.: Nitrogen Balance Studies in 4 Elderly Men, J. Gerontol. *6*:20 (Jan.) 1951.

3. Freeman, J. T.: Clinical Correlations in Geriatric Nutrition, J. Clin. Nutrition *1*:446 (Sept.-Oct.) 1953.

The Seal of Acceptance denotes that the nutritional statements made in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.

American Meat Institute
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Q. What is the status of triple sulfas in treatment of bacillary dysentery?

A. The pyrimidine derivatives (Meth-Dia-Mer) represent the treatment of choice in such infections because of their wide antibacterial range and relative absence of gastrointestinal side effects.

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Its accuracy is never affected by back-pressures or the type of administering apparatus used. Oxygen flow remains constant despite changes in cylinder pressure. Volumes delivered to the patient can be precisely controlled by just one valve.
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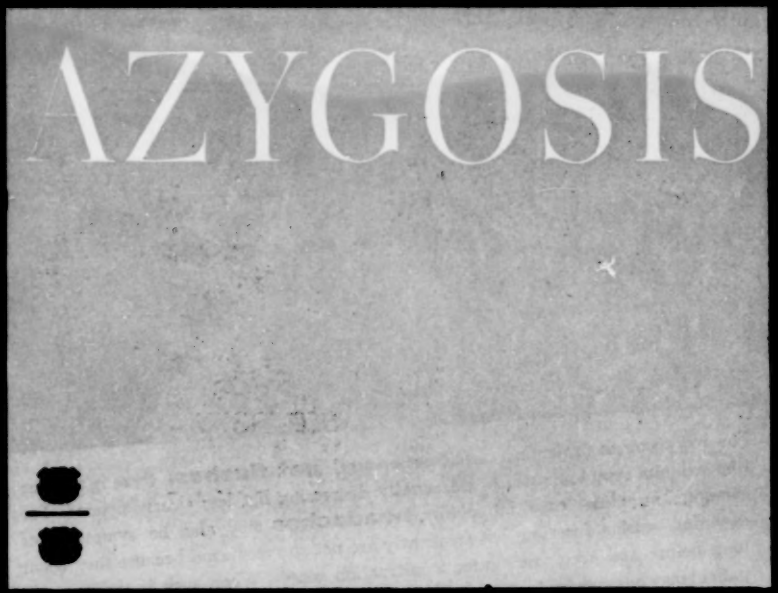

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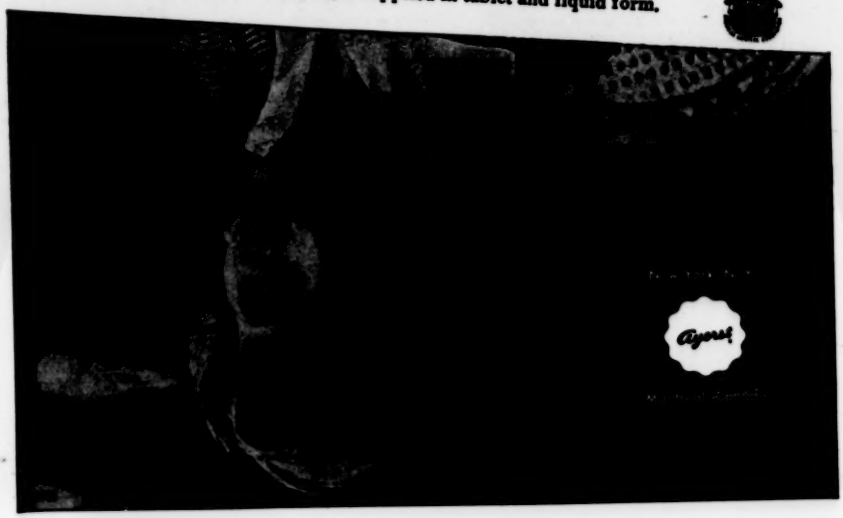
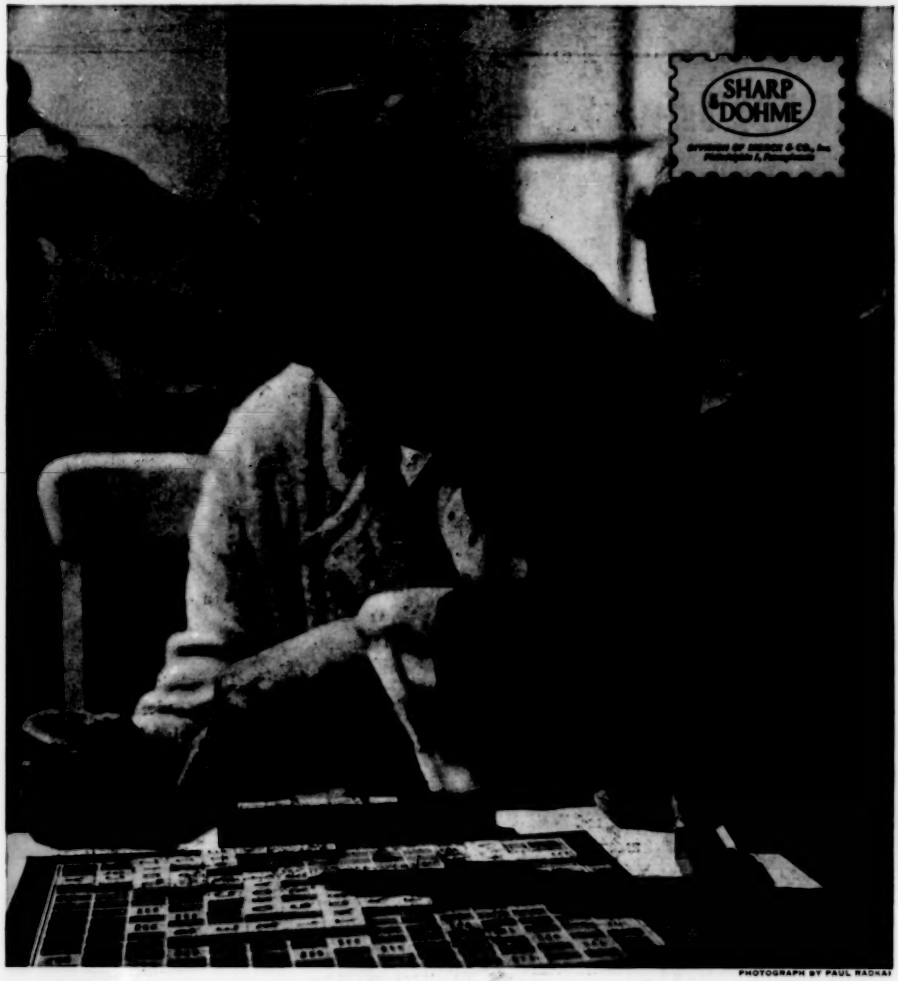
LANTEEN

For every woman presenting classic menopausal **hot flushes,** there is another who exhibits symptoms which are equally distressing but less clearly defined. For example, insomnia, easy fatigability, **headaches** may also be symptoms of declining ovarian function, but frequently are not so recognized because they occur long before and even years after menstruation ceases. When such is the case, the patient may be expected to **respond** to estrogen therapy. **"Premarin"** (complete equine estrogen-complex) produces not only prompt symptomatic relief but also imparts a gratifying **"sense of well-being."** It has no odor . . . imparts no odor. "Premarin"® estrogenic substances (water-soluble), also known as conjugated estrogens (equine), is supplied in tablet and liquid form.





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One investigator points out currently, SULFASUXIDINE "is the most satisfactory of the bacteriostatic sulfonamides available as an intestinal antiseptic."[1]

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Quick information: Daily dosage is 0.25 *Gm.* per kg. of body weight. Supplied in 0.5 *Gm. Tablets,* and as a *Powder* in ¼- and 1-lb. bottles.

References: 1. J. A. M. A. 153:1516, Dec. 26, 1953. 2. N. R. R. 1953, p. 95.

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SERTA is not concerned with therapeutic claims made by any mattress manufacturer; because we know that the diagnosis for any back pain cannot be made in a furniture store.

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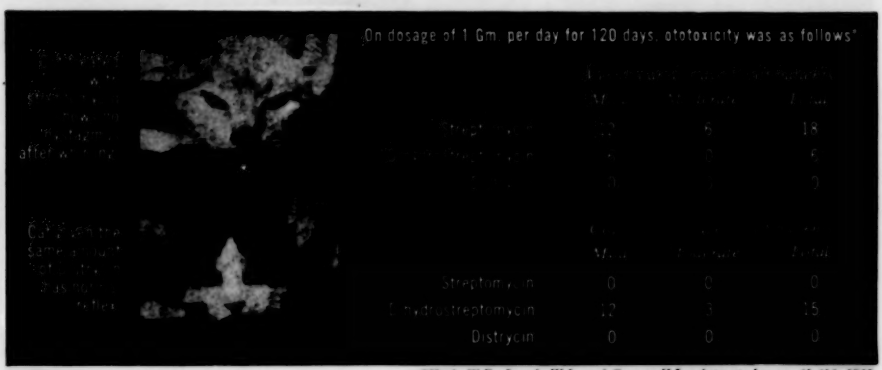
On dosage of 1 Gm. per day for 120 days, ototoxicity was as follows*
Streptomycin 0 0 0
Dihydrostreptomycin 12 3 15
Distrycin 0 0 0

*Heck, W.E.; Lynch, W.J., and Graves, H.L.: Acta oto-laryng. 43:416, 1953.

Distrycin dosage is the same as for streptomycin. In tuberculosis the routine dose is 1 Gm. twice weekly, in conjunction with daily para-aminosalicylic acid or Nydrazid (isoniazid). In the more serious forms of tuberculosis, Distrycin may be given daily, at least until the infection has been brought under control.

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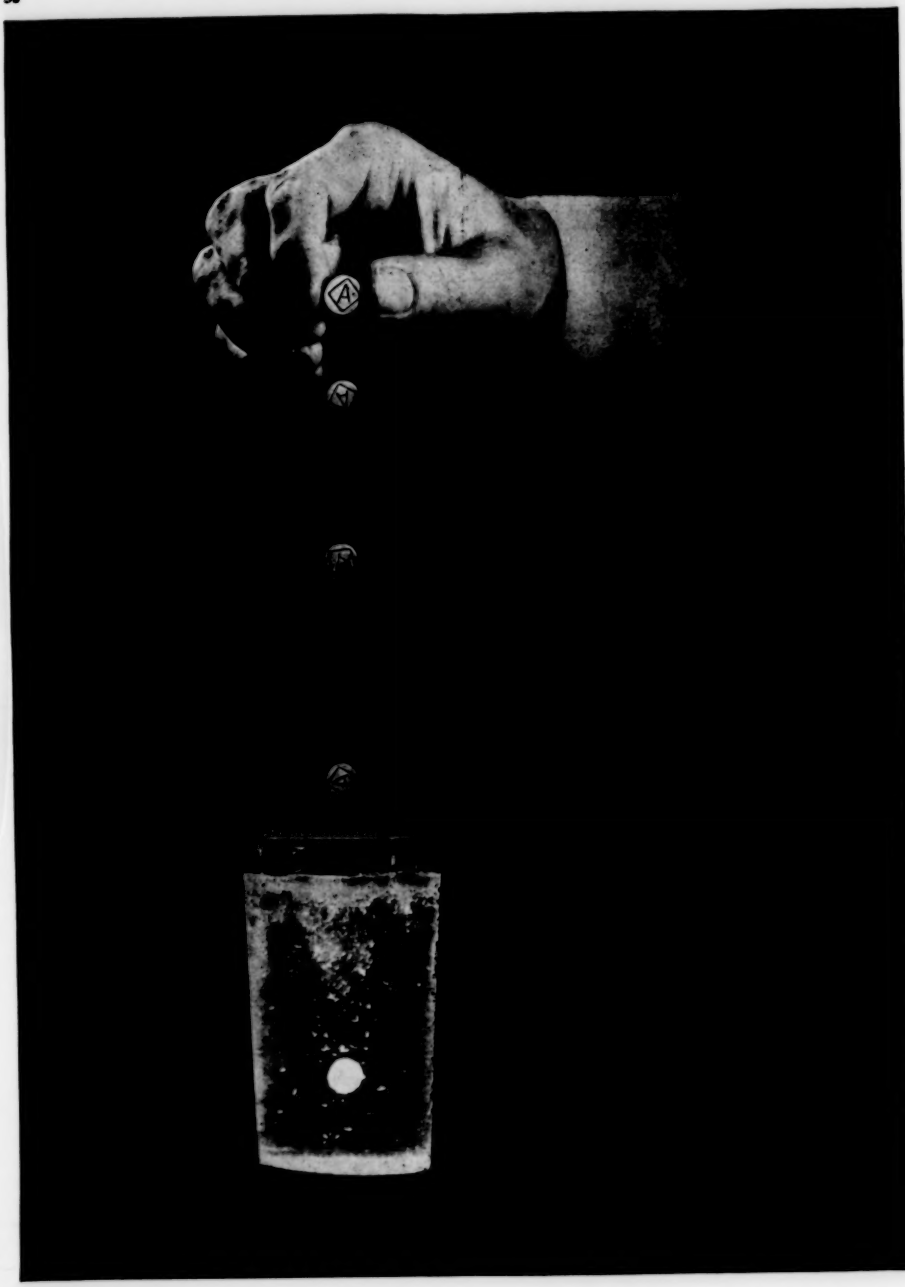

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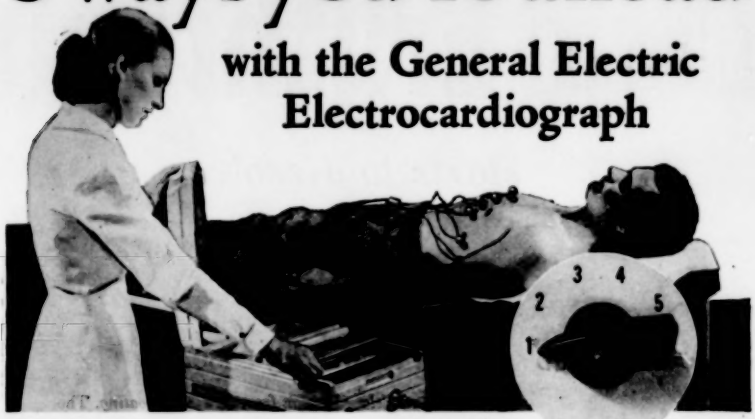

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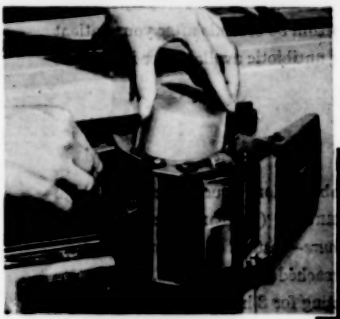

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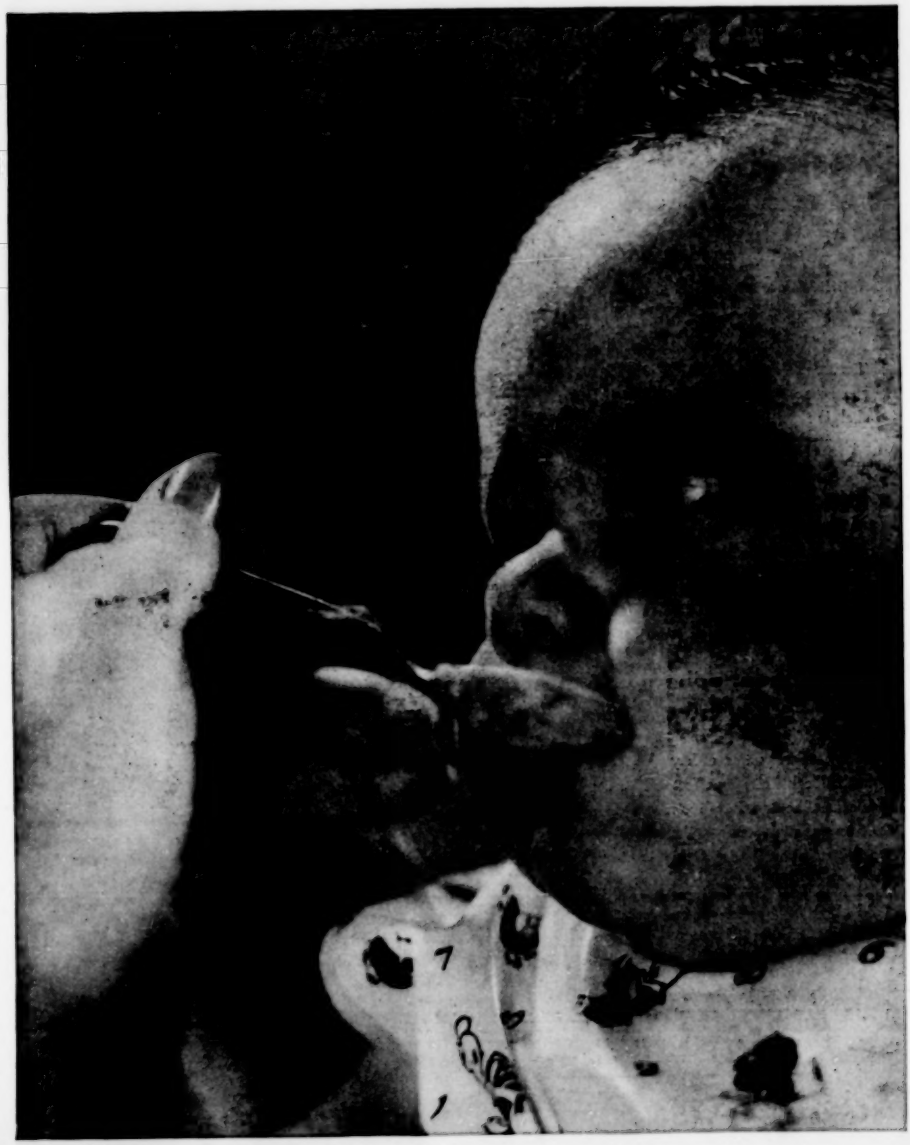

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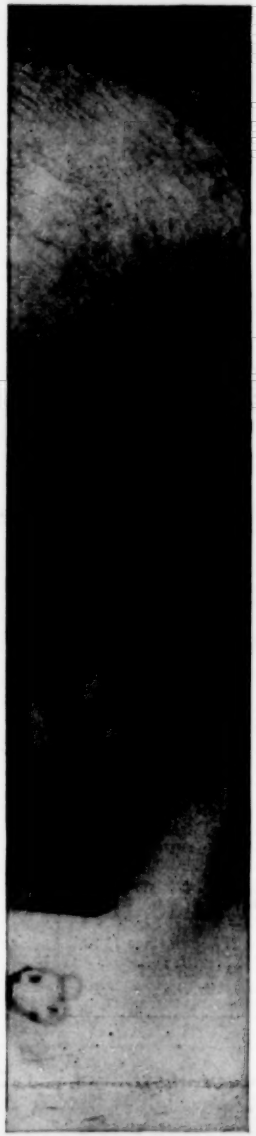

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CARCINOMA OF THE COLON WITH SPECIAL REFERENCE TO PREVENTION OF RECURRENCE

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and
Harry W. Southwick, M.D., Chicago

Carcinoma of the colon may be considered one of the most favorable of the intestinal cancers. Gradual, but slight, improvement in results has been achieved during the past several decades, owing largely to better preoperative and postoperative care of the patient and to performance of a more radical operation. Patients are coming to the physician earlier, but there is still too much delay between the onset of symptoms and the time of operation. Accordingly, there is need for insistence that patients go to a physician if rectal bleeding develops or abdominal discomfort of any kind persists longer than two or three weeks. Since clinical diagnosis is so difficult and roentgenographic examination (barium enema) so accurate in detecting carcinoma, examination cannot be considered complete without roentgenographic study.

Once the diagnosis is made it is the obligation of the surgeon to perform the type of operation that will be most likely to result in cure. It is our contention that implantation of malignant cells into the suture line may take place and malignant cell emboli to the liver may be produced at the time of operation unless precautions are taken. Prophylactic measures to prevent these two possible mechanisms of metastasis are described herein.

DIAGNOSIS

This paper does not discuss diagnosis other than to emphasize certain features related to early diagnosis, which is so essential to good results. There are no pathognomonic early manifestations. Pain is perhaps the most significant symptom, but it is notoriously variable in intensity and location. When obstruction develops, the pain becomes intermittent and cramp-like, but this a comparatively late symptom. Actually, the earliest significant manifestation is blood in the stool; it may be dark red or reddish black depending on the location of the lesion and the presence or absence of diarrhea.

In a recent study made by us of 136 consecutive cases of carcinoma of the colon 70% of patients with lesions on the right were anemic on admission whereas only 46% of patients with lesions on the left were anemic (see table). Contrary to the expected findings, 48% of the patients with tumors in the ascending colon and 64% of patients with tumors in the descending colon had blood in the stool (determined by laboratory tests). This is probably explained by the duration of the disease having been longer in patients with cancer on the right and the bleeding being more massive on this side, coming largely in attacks. An arbitrary level of 12 gm. of hemoglobin and a hematocrit of 40 was used in determining whether the patient was classified as having anemia. The most unfortunate feature revealed in the study of case records was that the average duration of symptoms before the patient came to the hospital was 11.2 months. It was slightly shorter in patients with cancer on the left side than on the right, owing probably to the fact that obstruction develops in a much higher percentage of patients in the former group.

The most accurate means of making a diagnosis is use of a roentgenogram with a barium enema. With this test there should be an error no greater than 5% in experienced hands. Accordingly, all patients with abdominal distress or rectal bleeding not explained on the basis of hemorrhoids or fissure should have a roentgenogram, which, however, should be preceded by proctoscopic examination, since tumors in the lower sigmoid will be visible by this procedure and often are missed by the radiologist. Another mechanism that can be used in obtaining earlier therapy is informing the public of dangerous symptoms and instructing them to seek medical advice if abdominal symptoms persist longer than a few weeks, or if rectal bleeding occurs.

RESECTABILITY AND CURABILITY

In a recent survey Grinnell [1] reported that the resectability rate for carcinoma of the colon at Presbyterian Hospital, New York, had risen from 50% in the period

From the Department of Surgery, University of Illinois College of Medicine, and the Illinois Research and Educational Hospitals.
Read in the General Scientific Meetings at the 103rd Annual Meeting of the American Medical Association, San Francisco, June 21, 1954.
Donald Hanscom reviewed the hospital records for the statistical data presented in this paper.
1. Grinnell, R. S.: Results in the Treatment of Carcinoma of the Colon and Rectum: An Analysis of 2,341 Cases over a 35 Year Period with 5 Year Survival Results in 1,667 Patients, Surg., Gynec. & Obst. **96**: 31 (Jan.) 1953.

from 1916 to 1920, to 92% in the period from 1945 to 1950. During these two periods the mortality rate dropped from 31.3 to 5.3%. These figures probably represent the average in large clinics except that the resectability rate may be higher than in most clinics. The resectability figure varies considerably, because there is a difference in opinion as to how often palliative resections should be performed. The truth still remains that no more than 50% of patients with carcinoma of the colon coming to operation can be cured; palliative operations are often performed (and justifiably so) to eliminate the ulcerating tumor, which so often gives rise to malnutrition and loss of blood.

Operative Technique.—As a prophylaxis against contamination incurred during the operation and against subsequent development of infection, phthalylsulfathiazole (Sulfathalidine), 6 gm. per day in divided doses, is given for four days before operation. Neomycin and oxytetracycline (Terramycin) by mouth are just as effective (perhaps more so) and require less time for the desired effect but are more expensive. Perhaps the most significant single change in the type of operation during the past several years has been the fairly universal adoption of the one stage procedure with the end-to-end type of anastomosis. Proximal colostomy is rarely performed now; the indication for addition of this procedure to the operation is an insecure suture line. The radical Mikulicz operation has also been abandoned. Almost the only indication for this procedure is the sudden collapse of the patient during the early part of the operation. If collapse occurs about the time the tumor is mobilized, and before completion of the suture line, exteriorization might be a lifesaving procedure. For sutures in the end-to-end technique we prefer interrupted sutures of 0000 nonabsorbable suture for the outside layer and interrupted sutures of 00 or 000 absorbable suture for the inside layer. Because of the danger of constriction of the stoma, use of a continuous suture is unwise. If used, it should be confined to the absorbable suture of the inside row and limited to half the circumference. This technique is entirely safe if gastric decompression is maintained for 48 hours after operation and oral intake of food is resumed slowly thereafter.

Numerous points are important in minimizing postoperative complications. It is essential that the two segments of intestine be sufficiently mobilized to allow approximation without tension. Equally important is preserving the blood supply to the ends of the intestine being approximated. Impaired blood supply is a common cause of leakage at the suture line; it may cause peritonitis and death of the patient. Fine needles and fine sutures, as mentioned above, are essential to prevent leakage and foreign body reaction. Use of a drain is controversial; when the suture line is insecure or the blood supply doubtful, insertion of a drain down to the area of anastomosis, or performance of a temporary proximal colostomy, may be helpful and even life saving. In spite of the effectiveness of preoperative "sterilization" of the intestine by various agents and the use of antibiotics postoperatively, aseptic care must be used throughout, although the open method of performing the anastomosis is permissible and desirable. The use of new measures to prevent local implantation of malignant cells at the suture line and to prevent venous emboli of malignant cells to the liver at the time of operation are described later.

Findings in 136 Consecutive Cases of Carcinoma of the Colon

Location and No.	No. of Patients	Sex	Average Age, Yr.	Duration of Symptoms, Mo.	Early Pain, %	Diarrhea, Constipation, or Normal, %	Vomiting, %	Obstruction, %	Blood in Stool, %	Palpable Tumor, %	Anemia, %	Red Blood Cells, Hematocrit, or Hemoglobin, Average
Right	28	M	59.4	13.3	72	D 27	18	26	48	70	76	R 3.79
50	22	F	....	....	..	C 29	....	....	..	..	..	H 30.9
..	..	..	....	....	..	N 44	....	....	..	..	..	Hb. 9.7
Transverse	11	M	61.9	11.7	71	D 29	47.8	47.8	59	64	35	R 4.2
14	3	F	....	....	..	C 57	....	....	..	..	..	H 39.3
..	..	..	....	....	..	N 14	....	....	..	..	..	Hb. 13.6
Left	40	M	57.0	8.7	67	D 20	22.2	34.7	64	51	46	R 4.2
72	32	F	....	....	..	C 56	....	....	..	..	..	H 37.2
..	..	..	....	....	..	N 24	....	....	..	..	..	Hb. 11.8
Total or	79	M	59.1	11.2	70	D 26	27.6	34.5	54	61	52	R 4.0
Average	57	F	....	....	..	C 47	....	....	..	..	..	H 35.8
136	..	..	....	....	..	N 27	....	....	..	..	..	Hb. 11.7

RECURRENCE AND INVASION OF THE TUMOR

Carcinoma of the colon, like most other tumors, spreads or invades by one or more of four different mechanisms: (1) lymphatic metastasis, (2) extension by contiguity, (3) local implantation, and (4) venous metastasis. As long as the tumor remains local, total excision can and does result in cure, providing the line of excision extends beyond the extent of the cancer. Unfortunately, cure in carcinoma of the colon depends on whether surgical excision extends beyond the existence of malignant cells, because secondary deposits, as well as the primary tumor, respond only slightly to x-ray therapy.

Lymphatic Metastases.—Spread by lymphatics takes place in certain tumors more commonly than in others. Malignant cells travel through lymphatic channels to lymph nodes; when a node becomes blocked with tumor, additional cells may extend around involved nodes to more distant nodes through collaterals. Obviously, cells may extend from one node to another node, usually in the direction of lymph flow, rarely against it. When surgical excision extends beyond the most distally involved node or lymphatic channel, cure may be expected unless

venous metastases have taken place; however, microscopic metastases may be present in nodes beyond the extent of excision and not be palpable. Recurrence by lymphatics has been discussed so adequately in the surgical literature that no additional comments will be made here.

Extension by Contiguity—Many tumors in the colon remain local for a considerable time, invading by contiguity and involving adjacent organs. Thus, on many

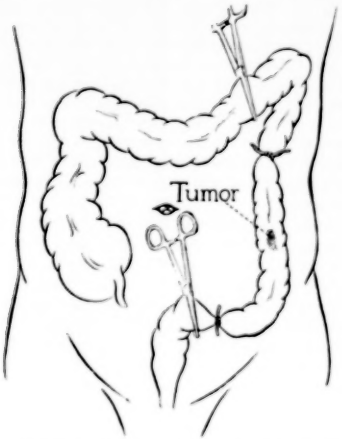

Fig. 1.—Ligature of the intestine several inches above and below the tumor to prevent local implantation of malignant cells into the suture line in colon surgery.

occasions, the tumors may become bulky by involving stomach, omentum, and a loop or two of small intestine before metastasizing. When metastases are not present beyond the extent of excision, cure may be accomplished by removing the local growth and adjacent organs so long as they are not necessary to life. Accordingly, the size of the local tumor should be no deterrent to its excision. Invasion by contiguity is, therefore, perhaps the least serious of all the types of extension.

Local Implantation.—A few years ago one of us (W. H. C.)[2a] became concerned about the frequency of local recurrence following resection of the colon for carcinoma. A survey of 55 consecutive patients[2b] revealed an incidence of local recurrence of 16%; in 10% of the entire group (6 of 9 patients with recurrences) the recurrent lesion was at the suture line where implantation appeared possible. An argument supporting the supposition that local recurrence may be due to implantation appears in the observation that, if the end of the intestine proximal to a resected tumor is brought out for a colostomy, local recurrence at the colostomy site is extremely rare compared to local recurrence at the suture line. We have observed only one such case of recurrence in a colostomy stump except in one or two patients with numerous polyps. If excision of colon proximal to the tumor is inadequate, crushing the end of the intestine with a clamp will not prevent recurrence unless the clamp happens to crush all of the invading tumor. On the other hand, contaminating cancer cells located at the point of crushing by a clamp would probably not grow but might survive and grow if they were implanted into the healthy vascular intestinal wall by a suture passing through the wall. Accordingly, if recurrence is due to implantation, the process of suturing appears to be a prerequisite. Goligher, Dukes, and Bussey [3] have also been concerned about the frequency of local recurrence at the suture line. Analysis of 162 of their patients having resection of a carcinoma of the colon revealed a local recurrence in 16, or 10%; another resection was carried out in 9 of the 16. They noted a local recurrence in 4 of 31 patients in whom the Hartmann operation (rectal stump turned in, not excised) was performed.

It does not appear likely that local recurrence at the suture line is due to inadequate excision of the distal segment, because retrograde extension takes place for such a short distance that the average resection should readily extend beyond the limit of retrograde extension. For example, Gilchrist and David [4] noted that lymphatic

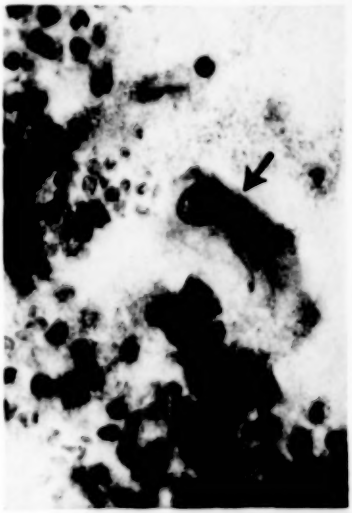

Fig. 2.—Malignant cells (arrow) in stained smear obtained by centrifuging blood and saline perfused through the vessels supplying a carcinoma of the rectum removed at operation.

spread was found 1 to 5 cm. distal to the tumor edge in only 4.6% of their cases. Goligher and associates [3] found lymphatic spread more than 2 cm. distal to the lesion in only 2% of cases. In a study of 89 patients

2. (*a*) Cole, W. H.: Measures to Combat the Menace of Cancer, Am. Surgeon **17**: 660 (July) 1951. (*b*) Cole, W. H.: Recurrence in Carcinoma of the Colon and Proximal Rectum Following Resection for Carcinoma, A. M. A. Arch. Surg. **63**: 264 (Aug.) 1952.

3. Goligher, J. C.; Dukes, C. E., and Bussey, H. J. R.: Local Recurrences After Sphincter-Saving Excisions for Carcinoma of the Rectum and Rectosigmoid, Brit. J. Surg. **39**: 199 (Nov.) 1951.

4. Gilchrist, R. K., and David, V. C.: Consideration of Pathological Factors Influencing 5 Year Survival in Radical Resection of the Large Bowel and Rectum for Carcinoma, Ann. Surg. **126**: 421 (Oct.) 1947.

Mayo and associates [5] noted that, excluding 2 patients who had clinically metastatic deposits, in only 1 of 89 patients had retrograde spread more than 1.5 cm. distally. Since surgeons rarely leave less than 1.5 cm. of uninvolved intestine distal to the tumor, it does not appear that inadequate excision of the distal portion of the intestine would be a common cause of local recurrence. If inadequate excision of the proximal segment is the cause of local recurrence then there should be more recurrences in colostomy stumps, because the cut end of the loop brought out for colostomy often is no farther from the tumor than the cut end anastomosed to the distal segment after resection of the tumor.

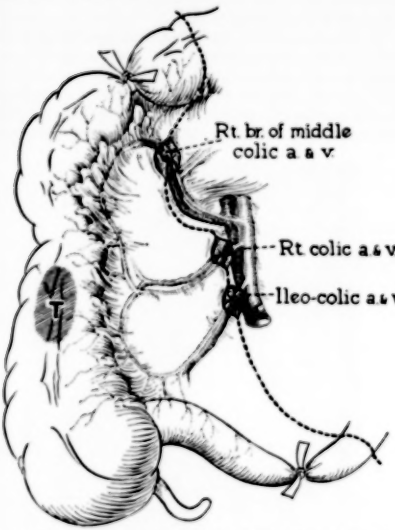

Fig. 3.—Ligation of the artery and veins (to be sacrificed) in ascending colon to prevent detachment of malignant cells from invaded veins within the tumor during operation.

The possibility of local implantation of detached malignant cells (particularly associated with manipulation at the time of operation) led one of us (W. H. C.)[2] to recommend ligation of the lumen of the intestine above and below the tumor before dissection is begun. Originally it was thought that special care should be exercised to prevent contamination of the suture line by live cells in local chemical treatment of the ends of colon after exclusion by ligatures. However, a study [6] of smears made from the lumen of the resected intestine just inside the ligatures indicated that the ligatures prevent survival of malignant cells beyond the ligature; for example, in five patients in whom occlusive ligatures were placed around the intestine above and below the tumor before resection was begun, eight smears taken outside the ligatures were normal, and seven of eight smears taken on the tumor side of the ligature showed malignancy. These and other data obtained from our study of smears indicate that malignant cells found in the lumen of the intestine after resection for carcinoma do not survive more than a few hours and apparently arise from the manipulation incident to resection. It would appear that if ligatures are placed around the intestine several inches proximal and distal to the tumor (fig. 1) before manipulation of the involved colon the danger of implantation of viable malignant cells could be minimized and perhaps eliminated.

Venous Spread.—For many years pathologists have called attention to the invasion of veins by tumors in the colon and rectum, but in our opinion clinicians have not attached sufficient importance to this finding. Studying microscopic sections, Dukes [7] found invasion of veins by tumor in the primary lesion in 17% of patients with rectal carcinoma and slightly less in lesions of the colon. On the other hand, Brown and Warren [8] noted an incidence of 61% in patients with carcinoma of the rectum; this study was made in autopsy cases and a higher incidence would be expected in such a group. In a study of specimens removed at operation, Grinnell [9] found invasion of the veins within the primary lesion in 36% of patients with rectal carcinoma, and in 33% of those with colonic carcinoma. In patients with and without venous invasion there was a ratio of five year survival similar to that found in patients with and without lymph node metastases; for example, in 51 patients with venous invasion the five year survival was 37% but was 76% in 82 patients without venous invasion. The five year survival was slightly higher in the 69 patients with lymph node metastases than in patients with invasion into the veins; for example, it was 41% in this group with node involvement compared to 83% in 64 patients without cancerous nodes. Barringer and associates [10] conducted a similar study in 45 specimens of carcinoma of the large intestine (27 colon and 18 rectum) removed by operation, but in addition took roentgenograms after injecting the veins with an opaque medium. The venous bed was perfused with warm tap water to flush out the blood, the lumen of the intestine was filled with water, and the ends were closed. Warm Brominol (a brominated olive oil containing about 33% bromine) was then injected into a large vein, its end ligated, and a roentgenogram taken. Of this group 51% showed venous occlusion by roentgenogram, whereas 38% of the specimens showed microscopic invasion of veins. It is significant that all except one of the specimens revealing microscopic invasion of veins showed roentgenologic evidence of invasion as indicated by obstruction.

5. Quer, E. A.; Dahlin, D. C., and Mayo, C. W.: Retrograde Intramural Spread of Carcinoma of the Colon and Rectosigmoid: A Microscopic Study, Surg., Gynec. & Obst. **96**: 24 (Jan.) 1953.
6. McGrew, E. A.; Laws, J. F., and Cole, W. H: Free Malignant Cells in Relation to Recurrence of Carcinoma of the Colon, J. A. M. A. **154**: 1251 (April 10) 1954.
7. Dukes, C. W.: Surgical Pathology of Rectal Cancer, Proc. Roy. Soc. Med. **37**: 131 (Feb.) 1944. Dukes, C. W., and Bussey, H. J. R.: Venous Spread in Rectal Cancer, Proc. Roy. Soc. Med **24**: 571 (July) 1941.
8. Brown, C. E., and Warren, S.: Visceral Metastasis from Rectal Carcinoma, Surg., Gynec. & Obst. **66**: 611 (March) 1938.
9. Grinnell, R. S.: The Spread of Carcinoma of the Colon and Rectum, Cancer **3**: 641 (July) 1950.
10. Barringer, P. L.; Dockerty, M. B.; Waugh, J. M., and Bargen, J. A.: Carcinoma of the Large Intestine: A New Approach to the Study of Venous Spread, Surg., Gynec. & Obst. **98**: 62 (Jan.) 1954.

We have carried this investigation still further on specimens removed by operation by examining the fluid (isotonic sodium chloride) perfused through the major artery and collected from the vein of a colonic segment containing carcinoma. This was done on only a few occasions, but malignant cells were found in a stained smear obtained from the perfused fluid in one of the cases (fig. 2). The fact that malignant cells can be found in fluid perfused through the vessels of a segment of colon containing carcinoma causes concern about the possibility of detaching malignant cells from invaded veins during the manipulation incident to resection; cells so detached would drift with venous flow to the liver, where metastases would develop. It should not be necessary to emphasize the danger of growth of such cellular emboli. One needs only to bear in mind how frequently metastases to the liver are found at operation to realize the grave importance of cellular emboli. When metastases from a colonic tumor are confined to lymph nodes it is almost always possible to include all of them in the resected specimen, and a five year survival is by no means impossible. As indicated previously, the five year survival after operation of patients having carcinoma of the colon with nodal metastases may be as high as 40%. However, when metastases (venous) are found in the liver, the only chance of cure is resection of the hepatic tissue containing the metastases; the five year survival in such cases will be low. Therefore, when venous metastasis has taken place, the prognosis is bad indeed; the only significant hope in this group of cases lies in prophylaxis.

In view of the danger of dislodging malignant cells (invading the veins) during the manipulation of resection we have adopted the practice of tying off the artery and vein to the involved segment of colon before the resection is begun. Usually it requires little manipulation of the tumor to determine resectability. When operating on the sigmoid it is practical to ligate the artery and vein (e. g., inferior mesenteric or superior hemorrhoidal vessels) before proceeding with mobilization of the intestinal segment containing the tumor. Many surgeons do this; however, we do not know of any surgeons who ligate the vessels on the ascending colon, transverse colon, and proximal portion of the descending colon before mobilizing the segment containing the tumor. There is no difficulty in ligating the vessels before mobilization of the tumor, but in patients with a fatty mesocolon some extra time may be required to locate the vessels. Figure 3 illustrates ligation of the three major arteries and veins during resection of the ascending colon. The amount resected for lesions in various segments of the colon is illustrated in figure 4 along with location of vessels involved in the resection. Usually severance of the inferior mesenteric artery at the aorta is indicated, particularly for lesions distal to the tumor area shown in figure 4. It is simple to isolate the vessels before mobilization of the intestine and to determine which vessels may be ligated and which must be preserved to maintain viability of the remaining segments. Whether one should ligate the lumen of the colon above and below the tumor before or after ligation of the vessels is apparently immaterial, but we recommend that both of these maneuvers be carried out before mobilization of the involved segment of colon.

SUMMARY

There are two possible mechanisms of metastasis that are not fully appreciated by surgeons. One of these is local implantation at the anastomotic line, caused, perhaps, by dragging detached malignant cells with the suture into the wall of the intestine, where they survive and grow. To prevent this, ligation of the lumen of the colon several inches above and below the tumor is recommended before mobilization of the involved intestine is begun. Smears taken from resected specimens between the ligature and tumor show cancer but are normal outside the ligatures. The second possible cause of metastasis that could be reduced is the detachment of malignant cells from the venules and veins within the tumor during mobilization of the specimen. Since malignant cells can

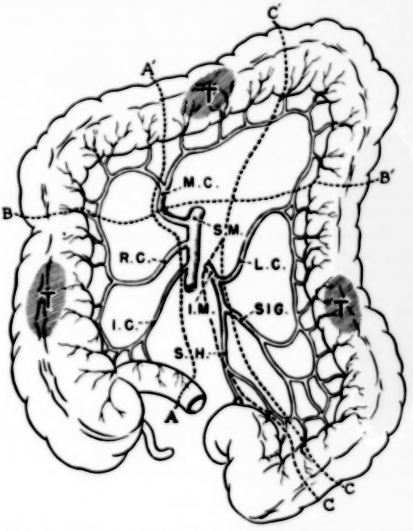

Fig. 4.—Segments to be removed for carcinoma of the colon in various locations indicating vessels to be preserved or to be ligated before the tumor is mobilized. For lesions of the ascending colon the line of excision *A* to *A'* would require severance of the ileocolic, right colic, and right branch of the middle colic vessels. For lesions in the transverse colon the line of severance *B* to *B'* would require severance of the middle colic and arcual vessels on each side. For lesions in the descending colon severance of the left colic and sigmoid vessels is required. The lines of excision indicated represent minimal lines of resection. Many surgeons routinely ligate the inferior mesenteric artery for lesions in the descending colon.

be found growing inside veins in or near the tumor, and malignant cells can be found in the saline solution perfused through the vessels of the tumor, the arteries and veins supplying the involved segment of colon should be ligated before the intestine is mobilized. In our opinion, use of these procedures will frequently prevent metastases that otherwise might develop. It appears logical to apply the same precautions to surgery of the small intestine and stomach for malignant disease, but it is technically more difficult to apply them.

1853 W. Polk (12) (Dr. Cole).

CRITERIA FOR THE SELECTION OF THE LEVEL OF AMPUTATION FOR ISCHEMIC GANGRENE

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Within recent years, the management of patients with gangrene, ulceration, and infection of the extremities associated with obliterative arterial disease and diabetes has undergone a conservative trend.[1] Chief among the factors responsible for the better prognosis of both limb and life are the use of antibiotics and better understanding of the peripheral vascular problems.

In the "Handbook on Amputations,"[2] published in 1942, the Council on Physical Therapy of the American Medical Association expressed the opinion of most surgeons when it advised the use of supracondylar amputations and warned against midleg amputations. This opinion was justifiable at the time of its publication, which was before the advent of antibiotics. Experience accumulated in the past decade with the use of these agents has shown that amputations below the knee at the metatarsal and toe levels are successful in a large number of cases. This experience indicates that a more conservative attitude is now fully justified.

There are five suitable levels for amputation of the leg. The decision as to which level to use can be made only after careful study of each individual case. It is the purpose of this paper to discuss, in the light of our own experience, the criteria for the selection of the level of amputation in cases of ischemic gangrene. Such a choice requires both proper evaluation of local factors and the patient's general condition. This study is based on a personal experience with 455 major amputations from 1939 to 1954. They are divided as follows: 43 midthigh, 331 midleg, 22 supramalleolar, and 59 transmetatarsal. In addition the study includes a considerable number of minor amputations limited to one or more toes.

CRITERIA

Chief among the local factors are the extent of gangrene or ulceration, degree of infection, condition of adjacent areas, degree of arterial impairment, and severity of pain.

Gangrene.—The extent of gangrene and the presence or absence of a line of demarcation are important factors. Our experience indicates that amputation of a gangrenous toe will frequently result in a gangrenous wound and is therefore usually not advisable. When gangrene is confined to the distal phalanx, the prognosis for healing after amputation of a toe is more favorable. In general, for gangrene of one or more toes, a transmetatarsal amputation is a safer procedure. For gangrene that involves the anterior third of the foot or the heel, midleg amputation should be done. When gangrene extends up to or beyond the middle of the leg, a thigh amputation is indicated.

The presence or absence of a demarcation line is important in the choice not only of the level of amputation but also of the proper time for surgery. Absence of a line of demarcation usually indicates a spreading process, which precludes a local conservative procedure. The presence of a demarcation line implies that the gangrene has become localized and that vascularity proximal to this point may be adequate for surgery. Unless the general condition of the patient contraindicates delay, it is always an advantage to wait for the development of a sharp line of demarcation.

In contrast to the poor results from amputation of a gangrenous toe, successful removal of an ulcerated toe is often possible. Chronic ulceration of toes frequently develops in patients with vascular disease, this ulceration is usually due to underlying osteomyelitis, and such lesions are difficult to heal. Amputation of an ulcerated toe can save a patient from many weeks of disability. Healing often takes place by primary union and frequently requires only two to three weeks. The prospect for success in amputation of one toe is greater if the ulceration involves the first or fifth toes.

Ulceration in the diabetic patient may involve the plantar surface of the foot, most commonly under a metatarsal head. Frequently it appears as an open infected area surrounded by thick callus leading to a denuded tendon or joint. Diminished or absent sensation to pinprick, loss of vibratory sensation, and absence of the Achilles reflex indicate the presence of diabetic neuropathy. The arterial supply is usually adequate. Healing of such a lesion is accomplished with bed rest and local dressings, but it tends to recur when weight bearing is resumed. In these cases, McKittrick advocates transmetatarsal amputations. He states, "If the incision on the plantar aspect is through skin with normal sensation, not only will healing be complete, but a good result may be expected."[1s] However, our limited experience has shown that this procedure is not always effective. Sympathectomy has likewise failed to prevent recurrent ulceration. Recently Beverly Smith has suggested excision of the ulcer and opening of the marrow cavity of the underlying metatarsal bone to obtain a new source of vascularity. He has had some success with this procedure.[1g]

From the Surgical Peripheral Vascular Disease Service of the Montefiore Hospital.

1. (a) McKittrick, L. S.; McKittrick, J. B., and Risley, T. S.: Transmetatarsal Amputation for Infection or Gangrene in Patients with Diabetes Mellitus, Ann. Surg. **130**: 826, 1949. (b) Warren, R.; Crawford, E. S.; Hardy, I. B., Jr., and McKittrick, J. B.: Transmetatarsal Amputation in Arterial Deficiency of the Lower Extremity, Surgery **31**: 132, 1952. (c) Silbert, S.: Mid-Leg Amputations for Gangrene in the Diabetic, Ann. Surg. **127**: 503, 1948. (d) Silbert, S., and Haimovici, H.: Results of Midleg Amputations for Gangrene in Diabetics, J. A. M. A. **144**: 454 (Oct. 7) 1950. (e) Edwards, W. S., and Linton, R. R.: Closed Lower Leg Amputations in Arterial Insufficiency, Surgery **34**: 688, 1953. (f) Shumacker, H. B., Jr., and Moore, T. C.: Leg and Thigh Amputations in Obliterative Arterial Disease, A. M. A. Arch. Surg. **63**: 458 (Oct.) 1951. (g) Smith, B. C.: Diagnosis and Evaluation of Therapy in Peripheral Vascular Disease, New York J. Med. **53**: 1849, 1953.

2. Handbook on Amputations, Chicago, American Medical Association, 1942.

Infection.—Local infection associated with gangrene is often present in varying degree. Since the advent of antibiotics and chemotherapeutic agents, infection can be controlled in most cases. This process, however, becomes a major problem when spreading lymphangitis or cellulitis are present and cannot be checked. In the presence of suppuration, surgery cannot long be delayed.

Toxemic manifestations, such as fever, mental confusion, and incontinence, accompanying local infection are indications for emergency surgery. Under such conditions it is unusually unwise to attempt a closed amputation. Either an open transmetatarsal or a guillotine amputation at the supramalleolar level eliminates the local area of gangrene and provides for free drainage. After this procedure the symptoms of toxemia subside rapidly, and a secondary amputation at the level of choice can be done safely.

Condition of Adjacent Areas.—Evaluation of the status of the tissues proximal to the gangrenous area is essential when local surgery is contemplated. Color changes, trophic lesions of the skin, edema, and bone involvement are important criteria. Thus, cyanosis of the skin proximal to the gangrenous area not reversible on elevation of the limb usually indicates advanced ischemia of the tissues and contraindicates local surgery. Thin, shiny skin with marked loss of subcutaneous tissue indicates poor vascularity. Edema, in the absence of venous obstruction or cardiorenal disease, is usually due to dependency and can be eliminated by keeping the leg horizontal. Localized osteomyelitis of phalanges or of metatarsal bones, although a serious local factor, is not regarded as a contraindication to toe or transmetatarsal amputation. In such cases it may be necessary to leave the amputation wound open, allowing healing by second intention.

Degree of Arterial Impairment.—In attempting to evaluate the degree of arterial insufficiency, clinical criteria usually provide most of the desired information. The acute or chronic mode of onset often determines not only the extent of the gangrene but also the level of amputation. The patency of major arteries is determined by palpation and checked with the oscillometer at various levels of the leg. While the presence of a popliteal or pedal pulse appears to insure prompter healing of a toe or transmetatarsal amputation wound, absence of these pulses does not represent a contraindication to surgery at this level. In the absence of functioning major arteries, it is axiomatic that the vascularization of the tissues depends on the degree of collateral circulation. Elevation-dependency tests, skin temperatures at different levels determined under basal conditions, and the degree of bleeding during operation are helpful guides in assessing the collateral arterial supply. Rapid blanching of the toes and foot on elevation and marked rubor on dependency suggest poor collateral circulation. Presence of a sharp difference in skin temperature between the proximal and distal areas of the extremity indicates recent arterial occlusion. Under these circumstances the level of amputation must be well above the cold area. When possible, surgery is delayed in the hope that collateral circulation may develop and thereby permit a more distal amputation. Likewise marked lowering of the skin temperature of the foot represents a contraindication to local amputation. In occasional cases, even in the presence of marked clinical signs of ischemia, fair bleeding during surgery was noted and good healing resulted.

Pain.—Pain associated with gangrene or infected ulcerative lesions has long been recognized as an important factor among the criteria for amputation. It is commonly present when gangrene is spreading. Pain radiating from the involved toes toward the ankle or leg and unrelieved by heavy sedation should be regarded as a contraindication to toe or transmetatarsal amputation.

Other Criteria.—Finally, in assessing the local factors, it is quite important to consider the duration of the lesions, the initiating cause, the effectiveness of previous treatments, the condition of the other leg, and, to some extent, the economic status of the patient. The general condition of the patient is evaluated as to age, severity of diabetes, toxicity, cardiac status, presence of hypertension, cerebrovascular accidents, renal function, and water-electrolyte balance. An attempt is made to grade each patient according to these factors. While the local signs are the chief criteria determining the level of amputation, in some patients the poor or precarious general condition is important in guiding the choice of the surgical procedure. For example, in a patient with heart failure or advanced visceral malignancy, a supramalleolar guillotine amputation is the quickest and safest operation.

LEVELS OF AMPUTATION

Single Toe Amputation.—The indications for single toe amputation through the proximal phalanx are (1) localized and well-demarcated necrosis of the distal end of the toes and (2) deep ulceration of the toe with denuded bone and exposed tendon. This procedure is mostly suitable for the second, third, and fourth toes. The indications for amputation of a single toe through the subcapital portion of the metatarsal, are about the same as for the former, except that this procedure is more suitable for the first and fifth toes. Every effort is made to control infection so that a closed amputation can be undertaken safely. In the presence of uncontrollable infection, the wound is left open; healing occurs secondarily.

Transmetatarsal Amputation.—The main indication for closed transmetatarsal amputation is limited gangrene of two or more toes (fig. 1). In the presence of uncontrollable infection associated with gangrene an open transmetatarsal amputation is indicated. In our series of 59 cases,[3] 78% of the amputations were done by primary closure, while only 22% were left open. Healing and a useful foot were obtained in 41, or 69% (fig. 2).

Factors favoring primary healing of closed transmetatarsal amputations are (1) well-demarcated gangrene of the toes not extending into the foot; (2) stabilized infection; (3) meticulous preoperative preparation of the skin; (4) adequate collateral circulation of the tissues at the level of amputation, as demonstrated by skin temperature and adequate arteriolar bleeding during amputation; and (5) gentle operative handling of the tissues.

3. Haimovici, H.: Criteria for and Results of Transmetatarsal Amputation for Ischemic Gangrene, to be published.

The technique of amputation is important. The incision in the skin and subcutaneous tissue should be decisive. The dorsal incision is done at the midshaft level, and the plantar incision is done at the level of the metatarsal heads. The toes are disarticulated, and the metatarsal bones with their respective tendons are separated from the plantar flap through the cleavage spaces; thus any unnecessary trauma is avoided. The bones are

Fig. 1.—Type of foot lesion suitable for transmetatarsal amputation.

divided with a Gigli saw and, if necessary, further shortened with a rongeur. Meticulous hemostasis is secured, and the wound is washed with warm saline solution. The flaps are approximated without tension. Drains are not used.

While the foregoing criteria have been a useful guide in determining the choice of this level of amputation, it should be noted that there is no accurate way of forecasting the results. With primary closure, healing is usually complete in three to four weeks. In patients with marginal necrosis of the flaps, healing is greatly delayed and ranges from a few weeks to six months. In our series of 46 cases with primary closure, 73.9% of the wounds healed either by primary or secondary intention and 26.1% did not heal and required midleg amputation (table 1).

The advantages of transmetatarsal amputation cannot be overemphasized. This is the only major procedure that makes it possible for an amputee to walk without the use of a prosthesis or crutches. Even though healing may be delayed in a certain number of cases, a transmetatarsal amputation is so desirable that it should be attempted whenever there is any prospect of success.

Supramalleolar Amputation.—Gangrene of the foot and spreading infection represents a serious surgical problem in patients in poor general condition. Despite the availability of antibiotics and blood transfusions, a major amputation still represents a great surgical risk in these cases. An open guillotine amputation through the lower leg just above the malleoli offers great advantages in such desperate cases. Its rapid execution and minimal surgical trauma are its chief assets. This amputation may be performed either as a definitive procedure in cases of intractable heart failure or malignant growths or as a preliminary step before operation at the site of election is feasible. After supramalleolar amputation toxemia subsides, the general condition improves quickly, and the diabetes is readily controlled. A midleg or thigh amputation with primary closure can then be done with much less risk.

In our series, 22 patients had a supramalleolar amputation. In 14 the amputation was done as a definitive procedure, while in the remainder it was preliminary to mid-

Table 1.—*Results of Transmetatarsal Stump Healing After Primary Closure*

	No. of Patients	Primary Union	Delayed Union	Reamputation
Diabetic	38	15 (39.5%)	12 (31.6%)	11 (28.9%)
Nondiabetic	8	3 (37.5%)	4 (50%)	1 (12.5%)
Total	46	18 (39.1%)	16 (34.8%)	12 (26.1%)

leg amputation in 7 and thigh amputation in 1. Of those with the definitive procedure, six patients improved and their wounds healed and eight patients died in the hospital from visceral malignancy or intractable heart disease.

Midleg Amputation.—We regard the following as indications for midleg amputation: (1) cases in which transmetatarsal amputation has failed and necrosis is spreading toward the ankle; (2) cases in which gangrene of several toes extends to or beyond the adjacent metatarsal regions and shows no tendency to demarcate;

Fig. 2.—Stumps after bilateral transmetatarsal amputation.

(3) cases in which spreading gangrene of the toes is associated with extensive gangrene of the heel or above the ankle (figure 3); and (4) cases in which spreading gangrene of several toes is associated with uncontrollable infection of the foot.

The operation is done with greater facility if the patient is in a prone position. The most desirable stump length is 5 to 7 in. (7.5 to 17.5 cm.). It is better to make

somewhat shorter anterior and somewhat longer posterior flaps. The skin is separated as little as possible from the underlying tissues. The muscles are stripped upward from the bones. A sharp bevel is made with the saw on the tibia before the bone is divided. This prevents the sharp anterior edge from pressing against the skin. The fibula is severed about 1 in. (2.5 cm.) higher than the tibia. The nerves are ligated but not injected. The wound is closed without drainage; interrupted sutures are used for the fascia and skin. A posterior molded plaster splint is applied to prevent contracture at the knee joint.

From September, 1939, to February, 1954, a total of 331 midleg amputations have been performed with a mortality rate of 7%. Of these 267 patients were diabetic and 64 patients were nondiabetic (table 2). In 183 closed midleg amputations, the mortality rate was 4.4%. Healing of the stump with primary closure usually is complete in two to four weeks. Delayed union due to marginal necrosis occurred in 20% of the cases (table 3). Infection, tension on tissues, and impaired arterial supply at the level of amputation are the three chief causes for marginal necrosis and hence for delayed healing of the

Fig. 3.—Type of foot lesion requiring midleg amputation.

suture line. Reamputation above the knee for gangrene of the stump was necessary in 3% of the cases. In 183 closed midleg amputations, 170, or 93%, of the wounds healed.

Thigh Amputation.—In our experience indications for primary thigh amputations are few. The ratio of midleg to primary thigh amputations performed between September, 1939, and February, 1954, on the ward service in the Montefiore Hospital for gangrene due to arteriosclerosis with or without diabetes was 160 to 33. Thus 17% of the total number of 193 amputations were performed at the thigh level; the mortality rate was 12.1%.

Analysis of these cases shows that there are three major indications for above-the-knee amputation: (1) extensive gangrene and infection of the leg with absence of the femoral pulse at the groin, (2) gangrene of the foot associated with painful flexion contracture of the knee joint, and (3) recent thrombosis or embolism of the femoral or iliac artery. In the latter cases it is not safe to amputate below the knee unless there has been an interval of at least three months after the acute arterial occlusion. This period appears to be the minimal time necessary for an adequate collateral circulation to develop to the midleg level.

Midleg amputation possesses three major advantages over thigh amputation: (1) lower mortality rates, (2) preservation of the knee joint with better prospect of rehabilitation, and (3) minimal or absent stump pain. The mortality associated with thigh amputation in obliterative arterial disease before the advent of antibiotics was distressingly high; the published figures ranged from 10 to 60% with an average of 27%.[1d] Since the use of antibiotics the operative mortality has declined, but few specific data on this point are available in recent publications.[4] In contrast, in our series of midleg amputation the over-all mortality was 7%. It is noteworthy that in 144 midleg amputations in diabetic patients treated with antibiotics and primary closure there were only five deaths, a mortality of 3.5% (table 2).

Preservation of the knee joint and about 6 in. (15 cm.) of the leg facilitates the use of a prosthesis. Rehabilitation of the amputee retaining his knee joint is much easier. Such patients are frequently able to walk without

TABLE 2.—*Number of Patients Who Died in Hospital After Midleg Amputations*

	Diabetics			Nondiabetics		
Method	No.	Deaths	Mortality Rate	No.	Deaths	Mortality Rate
Open	123	13	10.6%	25	2	8.0%
Closed	144	5	3.5%	39	3	7.7%
Total	267	18	6.7%	64	5	7.8%

TABLE 3.—*Results of Midleg Stump Healing After Primary Closure of Wound*

	No. of Patients	Primary Union	Delayed Union	Reamputation	Deaths
Diabetic	144	102	33	4	5
Nondiabetic	39	31	4	1	3
Total	183	133	37	5	8

the use of a cane and with scarcely any perceptible limp. In contrast, experience has shown that in the group of thigh amputations almost none of the women and only half of the men ever accustomed themselves to the use of an artificial limb.

Minimal or absent pain in the below-the-knee stumps is a third major advantage. Although phantom sensations or early postoperative stump pain are not unusual, persistent phantom limb or stump pain is rather exceptional in the midleg amputation, while it is common and distressing in thigh amputation.

REPORT OF CASES

CASE 1: Toe Amputation.—A 60-year-old man was admitted to Montefiore Hospital on Dec. 30, 1948. He had had diabetes for four years. In February, 1948, he injured his left great toe. Infection developed, which was slowly improved with local treatment, penicillin, and control of diabetes. Four months before his admission gangrene of the toe and considerable rest pain developed. The patient gave a history of intermittent claudication of five years' duration, more marked in the right leg, with a claudication distance of about three blocks. He had moderate hypertension, blood pressure of 170/100 mm. Hg, and advanced diabetic retinopathy. Both femoral pulses and the left popliteal pulses were felt. The right popliteal and all foot pulses were absent. Oscillometric readings were: left calf, 2,

4. West, J. S., and Papper, E. M.: Amputation in Patients with Diabetes Mellitus, New York J. Med. **49**: 1415, 1949.

left ankle, trace, and right calf and ankle, zero. There was localized gangrene of the terminal phalanx of the left great toe. He was treated conservatively, but since spontaneous separation failed to develop and pain persisted, a closed amputation of the toe through the metatarsal bone was performed on Feb. 1, 1949. On Feb. 26 all sutures were removed; the wound was healed. Two weeks later the patient was allowed to walk and was discharged from the hospital. Follow-up for three years showed a well-healed stump.

CASE 2: Transmetatarsal Amputation.—A 55-year-old man was admitted to Montefiore Hospital on Aug. 5, 1952. He was known to have had diabetes for 10 years. For seven months prior to hospitalization, the patient had had repeated infections of the right great toe. A week before his admission, gangrene of this toe and blisters on the three middle toes resulting from local application of heat were noted. Within six days after admission all the toes were gangrenous and he had moderate pain. On Aug. 14, examination showed that all the toes of the right foot were mummified and an infected ulcer was present on the plantar aspect. A roentgenogram showed destructive changes in the head and distal shaft of the fifth metatarsal. Both femoral pulses were felt. No other pulses were felt in either leg. The oscillometric readings below the knee were a trace bilaterally and at the ankle were zero bilaterally. On Aug. 15, a transmetatarsal amputation was performed. Osteomyelitis of the fifth metatarsal bone was found at operation. All necrotic and infected tissues were excised. The wound was closed without drainage. The patient's postoperative course was uneventful. On Aug. 29 all sutures were removed, the wound was dry and healed by primary intention.

CASE 3: Supramalleolar Amputation.—A 55-year-old man was admitted to Montefiore Hospital on Dec. 12, 1951, with gangrene of the right great toe. He was known to have been a diabetic for a few months only. In March, 1951, he had had a left midthigh amputation for gangrene of the foot in another hospital. In November, 1951, he had had a paronychia of the right great toe, but the infection could not be controlled with antibiotics. On the patient's admission to Montefiore Hospital the right great toe was gangrenous with cellulitis on the dorsum of the foot extending up into the leg and lymphangitis reaching the upper one-third of the leg. The right femoral pulse was felt. The popliteal and all foot pulses were absent. The temperature was 101 F and the pulse rate was 100 beats per minute. The patient appeared toxic, and his severe pain required narcotics every two to three hours. On Dec. 14, 1951, a right supramelleolar guillotine amputation was performed. Within three days the temperature became normal, the patient was no longer toxic, and the narcotic requirements diminished. On Jan. 2, 1952, a closed midleg amputation at the elected site was performed. On Jan. 18 all the sutures were removed and the stump was healed. The patient was discharged on Jan. 23.

CASE 4: Midleg Amputation.—A 65-year-old woman was admitted to Montefiore Hospital on Jan. 1, 1950. She was known to have been a diabetic for 10 years. Six weeks before admission, the patient noted a black spot on the right third toe that spread to involve the entire toe. Then gangrene spread to the second and fourth toes. When the patient was admitted, the lower two-thirds of the right leg was cold. Both femoral pulses and the left popliteal pulses were felt. The right popliteal and all foot pulses were absent. The blood pressure was 135/70 mm. Hg. An amputation was unavoidable, but because of the coldness of the leg it was decided to delay operation in the hope that development of collateral circulation might permit the knee joint to be saved. The patient was given antibiotics and vasodilators. Heart failure with pleural effusion was treated with digitalis and mercurial preparations. Two small transfusions were given because of marked anemia. While the patient was under observation, the gangrene spread to all the toes and extended further into the foot (fig. 3); however, the skin temperature of the leg improved down to the ankle. On Feb. 7, 1950, a closed midleg amputation was performed. On Feb. 28, all the sutures were removed and the wound was healed.

CASE 5: Thigh Amputation.—A 84-year-old man was admitted to Montefiore Hospital on Jan. 19, 1951. There was a history of intermittent claudication in the left leg of 14 years' duration. The onset of the present episode was marked by sudden pain, coldness, and numbness in the left leg about four weeks before his hospitalization. On admission, there was swelling of the left leg with distension of the superficial veins. All pulses were present in the right leg. On the left, only the femoral pulse was felt and the oscillometric readings below the knee were zero and above the knee were a trace. The diagnosis made was acute femoral arterial thrombosis associated with thrombophlebitis in a patient who had previous arteriosclerosis obliterans. Within a few days after his admission the foot became gangrenous. The process continued to spread and finally more than half of the leg became involved. The patient continued to have fever and severe pain. Due to the family's refusal, midthigh amputation was not performed until three months after the onset of the arterial occlusion, when the gangrene extended to 6 in. (15 cm.) below the knee. At the site of amputation, both the femoral artery and vein appeared thrombosed. The wound was closed and primary healing of the stump occurred within three weeks. The patient was discharged a few days later.

SUMMARY AND CONCLUSIONS

In experience with 455 cases of ischemic gangrene, it was found that choice of the proper level for amputation depends on careful evaluation of local factors and the patient's general condition. Chief among the local factors are extent of gangrene or ulceration, degree of infection, condition of adjacent areas, degree of arterial impairment, and severity of pain. There are five suitable levels for amputation of the leg. Conservative amputations are advocated.

Single toe or transmetatarsal amputation permits rehabilitation without the use of a prosthesis. Supramalleolar amputation offers great advantages in patients in poor general condition because of its rapid execution and its minimal surgical risk. The advantages of midleg over thigh amputation are lower operative mortality, better prospect of rehabilitation, and absence of persistent stump pain. In our experience, thigh amputations are required in only a minority of patients with gangrene.

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Antibiotic Treatment of Skin Diseases.—Antibiotic therapy should only be used where there is a specific indication and the drugs should be administered in adequate dosage. Long continued systemic administration of any of the antibiotics is not considered good practice because rest periods are necessary to prevent the destruction of the natural flora of the skin. The ideal drug for local applications is one which is not used for systemic administration. Penicillin is the drug of choice in the treatment of syphilis, but aureomycin, oxytetracycline, chloramphenicol, and erythromycin are also spirocheticidal. The antibiotics are indicated in the treatment of the pyodermas. Local therapy will suffice in most cases of impetigo contagiosa, ecthyma, and secondarily infected dermatoses. Systemic administration is necessary in furunculosis, erysipelas, lymphangitis, and cellulitis. All of the systemically administered antibiotics except penicillin produce healing of granuloma inguinale lesions, but to prevent relapses treatment must be continued for at least one week after all lesions have healed and the dosage must be adequate. The majority of patients with erythema multiforme will respond to treatment with all of the systemically administered antibiotics except penicillin and streptomycin. The antibiotics are an adjunct to the treatment of acne vulgaris, but do not replace the standard method in present-day use. Antibiotic therapy is contraindicated in moniliasis, gastroenteritis, chronic discoid lupus erythematosus, and in diseases where statistical studies prove them to be of no value and their systemic administration is contraindicated where there is a history of sensitivity to their local application.—H. M. Robinson Jr., M.D., Uses and Abuses of Antibiotics in the Treatment of Dermatoses, *United States Armed Forces Medical Journal*, July, 1954.

PERIPHERAL VASCULAR DISEASES AND THEIR CURE

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The subject of peripheral vascular diseases includes the insufficiencies of peripheral blood flow in veins, minute vessels, and arteries. Cure means eradicating the cause; when this is not possible, it means permanently augmenting the blood flow within the residual and collateral vessels. Venous insufficiency caused by phlebitis or varicosities cannot be cured by either approach. The dilatation of collateral veins will result in more varicosities. Extirpation of diseased veins by stripping or sclerosing is palliative, and when the process is repeated for each recurrence, it inevitably leads to a state of irreversible edema.

Disease of the minute vessels as manifested in Raynaud's disease and scleroderma is cured by eradicating the cause, a psychosomatic derangement.[1] An attempt to influence collateral vessels is made only when the disease has advanced to the thrombotic phase. Peripheral arterial insufficiency is rarely cured by removing the cause, but it is very frequently helped by treatment that causes a dilatation of collateral vessels. Because of our increasing span of life, the arterial obliterative diseases have become important as a cause of death. I will therefore present a definitive regimen for the cure of these diseases, which, in my seven years' experience [2] and in that of four groups [3] here and in England, has had a great degree of success.

Arteriosclerosis without or with diabetes, thromboangiitis, and multiple or single emboli are the most common causes of a progressive or rapid closure of peripheral arteries. When a reduction in blood flow follows, symptoms develop. Symptoms without physical signs are not enough evidence on which to make the diagnosis of arterial insufficiency. The vascular examination should include palpation of arterial pulsations from the inguinal fold to the foot, taking oscillometric readings on the leg, timing the return of color to a warm dependent foot that has been blanched by elevation, and neurological and orthopedic appraisals.[4]

The earliest symptom of peripheral arterial insufficiency is claudication or reduced walking tolerance. It is often simulated by the intermittent limping that develops because of static muscle imbalance in poliomyelitis, dorsal column sclerosis, peripheral nerve disease, and arthritis. Another symptom developing when the insufficiency is more advanced is limited sleep tolerance—that is, pain in the calf or foot appearing while the patient is at rest horizontally that is relieved only by standing. This symptom may be mimicked by the stretch reflex of a contracted gastrocnemius muscle, calcaneal tendon, or plantar fascia; it may also be seen in venous insufficiency. When digital infection resists therapy in a diabetic patient, it need not be caused by arterial disease. This mistake in diagnosis too often causes delaying tactics that can convert a minor disease into a major tragedy. Even gangrene or infarction of tissue need not have an arterial basis. These can occur when severe lymphatic stases develop during a painful infection. Peripheral neural disease very often is, but need not be, a complication of obliterative disease. The loss of vibratory sense in diabetes can be caused by subclinical arteriosclerosis of the end arteries supplying peripheral nerves or by a neuritis caused by diabetes or a vitamin deficiency. A calcified artery when seen roentgenologically does not necessarily have an obstructed lumen. There is nothing more futile than the discovery after several weeks of therapy with vasodilators that the patient has no obliterative vascular disease. It is well to remember that diseases real and simulated can coexist in a patient and thus complicate the choice of treatment.

TREATMENT

With the diagnosis of reduced blood flow and its causes clearly established, the basis and type of treatment should be considered. To reverse the disease by changing the pathological picture is impossible. A single early embolism can be milked or aspirated; multiple packed emboli cannot. Arteriectomy can be considered; but one need only look at the pathologist's slide to realize that it is impossible to peel off inflammatory and calcified plaques or organized thrombi and expect a new normal endothelium. Excision of the artery and its block and replacement or circumvention with a graft in the presence of arteriosclerosis should not be altogether feasible because of the usually diffuse distribution of brittle walls and blocked lumens. Our efforts can best be directed to the collateral vessels that circumvent the block in a large artery. The status of the collateral vessels and that of the blocked artery should first be analyzed, because prognosis and treatment will depend on them. To do this the following steps should be taken. The degree to which blood flow satisfies the metabolic needs of all tissues should be observed. This is best done by history and physical examination. The location and number of complete or partial blocks in the arterial system should be known. An aortogram or arteriogram would help, but neither is simple to perform. The pulses and oscillometric readings can be as informative. The collateral arteries may not be present, or, if they are present, they may be unavailable between points above and below the blocks; both are futile situations. When available but insufficient, there is the hope that treatment will succeed. Symptoms of claudication do not develop when the vessels are sufficient. If they are insufficient, how does one determine

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2. Mufson, I.: Treatment of Peripheral Arterial Obliterative Diseases and Their Complications by Arterial Infusions of Histamine, Am. J. Med. **12**: 680-687, 1952.

3. Mackey, W. A.: Intra-Arterial Histamine in Treatment of Claudication and Rest Pain, Brit. M. J. **2**: 106-1089, 1950. Swann, W. C.; Cook, J. R., and Yates, W. K.: Treatment of Occlusive Peripheral Arterial Disease by Intra-Arterial Histamine, West Virginia M. J. **46**: 149-152, 1950. Flanders, J. F.; Heckler, G. B., and Jones, R. E.: Intra-Arterial Histamine in Peripheral Vascular Disease, Delaware M. J. **24**: 17-21, 1952. Dixon, J. A.; Scott, W. J. M., and Epstein, M. A.: Intra-Arterial Histamine in the Treatment of Occlusive Peripheral Arterial Disease, Circulation **5**: 661-669, 1952.

4. Mufson, I.: Intermittent Limping—Intermittent Claudication: Their Differential Diagnosis, Ann. Int. Med. **14**: 2240-2245, 1941.

the presence, availability, and adequacy of collateral vessels? These can be made known only by trying to dilate them. If there are no collateral vessels, nothing happens. If they are present and capable of being dilated, the skin will lose its pallor or mottled cyanosis and become pink. The skin temperatures will rise and the superficial veins will dilate. The degree of adequacy of the vessels will be proportionate to the intensity of the changes caused by active dilatation. The agent used for this purpose must be consistently effective, powerful in its action, and self-limiting in activity to the affected limb. The tonus of an arterial wall is normally determined by fluctuations in the volume of circulating blood. Neurogenic stimuli also change the lumen when the stimuli reach the artery via sympathetic ganglions and somatic nerves.

The circulating and local vasomotor effectors such as acetylcholin, histamine, and *l*-arterenol (*l*-norepinephrine) also vary local tonus. No known vasodilating drug or method will block all the effectors. By the comparative testing of many vasodilators with the help of radioactive sodium [5] and skin temperature changes,[6] I am satisfied that an arterial infusion of histamine comes closest to this ideal when severe arterial disease is present. A lumbar sympathetic block is inadequate because its dilatation will include pelvic arteries and is weaker than that of indirect warming.[7] The lumbar block affects the sudomotor system of the leg to give false values to the temperature changes, and it cannot cause an erythema of the skin. When no change follows its use, one can never be certain whether the needle has missed the ganglia or whether there are no available collateral vessels. The erythema that histamine produces acts like a tracer of collateral vessels when its pink coloration spreads or fails to spread from groin to toes. The absence of erythema means the absence of collateral vessels. This is the basis for my exclusive use of histamine to quantitate collateral vessels. Prognosis based on this method will help avoid that embarassing moment when one is confronted by a patient who has been advised to have an amputation and who, six months later, is walking comfortably with his own legs. At the same time serious extravascular disturbances may be present. These will affect local blood flow and confuse prognosis. The most frequently encountered disturbance is edema. It can be caused by the phlebitis of thromboangiitis, varicose veins, congestive heart failure, infection, or prolonged dependency of the limb. Fear and pain, when present, also alter blood flow by causing reflex vasospasm. This is difficult to overcome unless the cause is treated.

With a knowledge of the cognate block and the availability of collateral vessels established, one is prepared to decide on a basic type of treatment for the patient. Some men recommend for all patients the so-called natural history method, in which the patient waits for the spontaneous development of collateral vessels. Data on this method are not available. What often does occur is that walking tolerance seemingly increases with each reduction in speed of the patient's gait. The reduction is made either from exhaustion or by intent. The patient who must work for a living wage and the non-Spartan patient require a regimen that helps them quickly and frequently. When pain prevents sleep every night, patience is beyond human capacity and addiction is in the offing. If infection is present and life and limb are menaced, waiting for self-delimitation is dangerous and often necessitates amputation. The best treatment available must be offered first, and not after prolonged trial and error. Ninety per cent of my patients had, before they came to me, had their patience strained by protracted treatment.

HISTAMINE THERAPY

My choice of the vasodilator is histamine. It is a natural product of our bodies; when properly given through the artery it is safe and is the most powerful vasodilator. It has given results far better than those I had previously obtained with other types of treatment. Why is histamine given by arterial infusion? The reasons are significant because they help understand the intent and physiological basis of all treatment in these diseases.[5a] Histamine is too powerful to be given in concentrated solutions. I first gave it intravenously by infusion. A reduction of blood flow in the poorly vascularized foot and calf followed. This could be explained only by the fact that the blood volume, being fixed in quantity, was redistributed to first fill the healthy, elastic, easily dilated blood vessels; thus the inelastic, narrowed collateral vessels had an insufficient volume of blood. To prevent this undesirable redistribution of blood, the dilator was introduced into the artery leading to the involved limb. A method for its introduction was devised and first published in 1948; the treatment was found to satisfy all physiological criteria, and it produced no ill effects locally or systemically.[5]

How can the high percentage and permanency of success that had been reported in the treatment of intermittent claudication with arterial infusions of histamine be explained? The reason must be that a permanent structural increase in the diameter of the collateral vessels is developed during treatment. This thesis is supported by the following annotations. Thoma,[9] Clark,[10] and Quiring [11] state that structural enlargement of the arterial musculature and lumen follows when the blood flow and pressure are increased within the artery. According to Poiseuille's law, when an artery dilates the flow increases in proportion to the fourth power of the increase in diameter. Therefore, a method of treatment that can cause the greatest degree of vasodilatation and therefore the largest increase in blood flow will produce the most powerful impetus for structural enlargement of the col-

5. (*a*) Mufson, I.; Quimby, E. H., and Smith, B. C.: Use of Radioactive Sodium as Guide to Efficacy of Drugs Used in Treatment of Diseases of the Peripheral Vascular System: Preliminary Report, Am. J. Med. **4**: 73-82, 1948. (*b*) Mufson, I.: Responses of the Abnormal Arterial Circulation to Various Stimuli, as Studied by the Use of Radioactive Sodium: II. Intra-Arterial Histamine, Papaverine, Aminophylline and Adrenaline: Sympathectomy and Etamon: Pain, Ann. Int. Med. **34**: 428-441, 1951.

6. Mufson, I., and others: An Evaluation of Priscoline by Artery in the Treatment of Peripheral Arterial Obliterative Disease, New York, J. Med. **52**: 2651-2654, 1952.

7. Lynn, R. B., and Barcroft, H.: Circulatory Changes in Foot After Lumbar Sympathectomy, Lancet **1**: 1105-1108, 1950.

8. Mufson, I.: New Treatment for Relief of Obliterative Diseases of Peripheral Arteries, Ann. Int. Med. **29**: 903-913, 1948.

9. Thoma, cited by Lewis, T.: Vascular Disorders of the Limbs: Described for Practitioners and Students, 2nd ed., Toronto, the Macmillan Company, 1946.

10. Clark, E. R., and Clark, E. L.: The New Formation of Arterio-Venous Anastomoses in the Rabbit's Ear, Am. J. Anat. **55**: 407-467, 1934.

11. Quiring, D. P.: Collateral Circulation: Anatomical Aspects, Philadelphia, Lea & Febiger, 1949.

lateral vessels. I have made comparative observations on the efficacy of vasodilators. These were based on the development of erythema, rise in temperature of the skin, radioactive sodium measurements,[5] and dye flow studies. These show that histamine is far more powerful than sympathetic blocks [5b] or than tolazoline (Priscoline) given per artery.[6] Plethysmography shows that lumbar sympathectomy causes a vasodilatation that is milder than that caused by indirect warming [7] and that does not persist longer than four to six weeks.[12] Clinically, the results show that histamine therapy is most effective in increasing walking tolerance. In 40% of the patients treated, this improvement persisted for from two to seven years. Similar success followed histamine therapy in those patients who failed to be helped by lumbar sympathectomy and tolazoline administered per artery. Since all methods of vasodilatation last from hours to weeks at most, if permanent clinical improvement does follow it cannot be caused by temporary release of vasospasm alone. Prolonged success must be the result of structural changes in the collateral vessels. Because histamine therapy combines the largest percentage of success and the greatest degree of vasodilatation and increase in blood flow, it is axiomatic that causing permanent structural enlargement of collateral arteries requires the impetus of repeated extremes of localized vasodilatation.

RESULTS

My results have been the statistical background for the observations made above. The factors noted in the study were (1) the time period each patient had spent seeking relief before trying histamine; (2) my high percentage of treatment failures with arterial injections of tolazoline; and (3) my success with histamine therapy in patients who had failed to obtain relief with sympathectomy. Placebos cannot be used, because the erythema and local warmth of histamine cannot be simulated. The arterial infusions were made into femoral and popliteal arteries in well over 200 patients without local thrombosis, even when antibiotics were included. There were no systemic or visceral ill effects and no deaths. Persons with asthma were excluded. All the patients except those with thromboangiitis obliterans were permitted to smoke.

The patients treated have been divided into two main groups. In one, treatment was considered elective; in the other, mandatory. Intermittent claudication caused by pain in the foot, calf, or thigh is the salient feature of the patients in the first group. This group has been further subdivided. The first subgroup had 150 patients with the following characteristics: the only pulsation in the leg was that of the femoral artery at the inguinal fold, and the oscillometric readings in the upper third of the leg were between zero and one with four exceptions. If, after 10 or more infusions, there was no or very little improvement, treatment was considered a failure; this result was obtained in 12%. If walking tolerance increased between a minimum of three times the amount the patient could originally walk and seven blocks, it was a good result; 36% attained this improvement. If walking tolerance increased to an amount over seven blocks up to an unlimited distance, it was rated very good; this amount of success was obtained by 52% of the patients. Of the very good group, 40% of the patients remained improved, some for as long as two to seven years. None had side reactions.

In the second subgroup are those patients reported on by other physicians who have also used histamine exclusively for the treatment of intermittent claudication. There were four groups of physicians reporting here and in England.[3] They treated 41 patients and found that 70% walked better and 30% did not. There were no ill effects.

For contrast a clinically similar group of 23 patients who were treated with repeated arterial injections, not infusions, of 25 to 50 mg. of tolazoline is included. Only 1 patient had a very good result, 5 were classified as having good results, and 17 did not have good results. There were too many serious side-effects during treatment—shock, convulsions, angina, and death—to continue this method of administering tolazoline even if it had been more effective.[6]

In the third subgroup are patients with intermittent claudication who did not have any palpable femoral pulse in the inguinal fold. The arterial block as shown by aortagram was located in the iliac artery or in the aorta. The oscillometric readings, with one exception, were zero. We were able to find the lumen of the femoral artery at the inguinal fold and to successfully complete a series of infusions. The response of the patient's walking tolerance to this treatment was good in 12 patients and failed in five. The technique of finding a femoral lumen when there is no guiding pulsation is more difficult than when the pulsation is present.

In the fourth and last subgroup of patients with claudication, none had popliteal pulse and a few had no femoral pulsations. They all had had either unilateral or bilateral lumbar sympathectomies. Some could not sleep. After a series of arterial infusions of histamine, I was able to increase the walking tolerance in seven and unable to increase it in two.

In the second main group are the patients whose disability was so great that in the majority amputation was being contemplated. Often their referral for medical treatment was considered merely a standby until operative intervention was accepted by the patient. Amputation is not always the easy way out. Failure may be inevitable, but a decision to amputate just to shorten the time of treatment does not guarantee the patient a well-healed stump and a useful prosthesis. Often one must care for an infected, ulcerated, and painful stump, osteomyelitis, sequestrums, fistulas, poor healing, contractures of joints, causalgia, and an ill-fitted prosthesis. Everything possible should be done to save the first involved limb. Especially in the patient with arteriosclerosis, the other limb often has impaired circulation. With the added strain of the prosthesis, its tissues become easily embarrassed, and a double amputation is in the offing.

The large group of patients with great disability has also been subdivided. In the first subgroup are patients who cannot remain in bed because pain in the foot or

12. Barcroft, H., and Swan, H. J. C.: Sympathetic Control of Human Blood Vessels, London, Edward Arnold & Co., chap. 7, 1953. Dornhorst, A. C., and Sharpey-Schaefer, E. P.: Collateral Resistance in Limbs with Arterial Obstruction: Spontaneous Changes and Effects of Sympathectomy, Clin. Sc. **10**: 371-381, 1951.

calf forces them to hang their legs over the side of the bed or to stand in order to gain relief. Many had superficial infarctions of the skin. After 10 histamine infusions or less, 52 patients obtained complete relief of the pain in calf or foot and could sleep again. Five patients whose pain in the foot was most intense did not improve.

A small group of five patients had acute neural ischemia. The major manifestation of ischemia was foot drop. With treatment, three patients regained their motor function and two did not.[13] Chronic ischemic neuritis was infrequently helped unless it was mild and the patient was seen within the first few months.

There were 24 in a subgroup of patients with severe infection. Many had, as could be expected, gangrene. All had previously been treated with bed rest and drugs and antibiotics administered by mouth and subcutaneously. It seems futile to treat an infection by keeping the patient in bed without trying to improve collateral circulation. Even if a minor infection is helped in this manner, the tissues still remain just as vulnerable, if not more vulnerable, to trauma and reinfection. Treatment has to contend with such variables as the virulence of the infecting organism, its spreading quality, the extent and location of the necrotic tissues, and the state of the collateral circulation. Infusions of histamine and antibiotics were given daily at first and less frequently if the situation improved. If the pain was intensified by the vasodilatation, the peripheral nerve supplying this area had to be blocked with procaine to permit completion of the infusion. The antibiotics available for intravenous use were chosen on the basis of wound culture and antibiotic sensitivity tests. The plasma concentration of the antibiotics was often found to be two times as great in the femoral vein as in the brachial vein one hour after the completion of the infusion. The antibiotics included penicillin, chlortetracycline (Aureomycin), oxytetracycline (Terramycin), streptomycin, erythromycin, and, rarely, bacitracin. Hopeful signs during treatment that point to success are relief of pain, drop in body temperature, and increasing spread of the histamine erythema. Infusions must be given until healing is complete or until the persistent spread of gangrene or infection makes amputation necessary. In this group of seriously ill patients, 6 had amputations and the remaining 23 returned to their normal routines. The cases reported illustrate two of the problems that were successfully met with the use of histamine therapy.

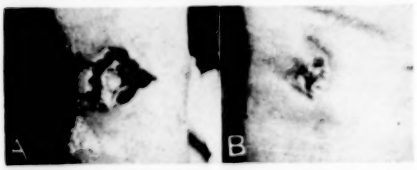

Fig. 1.—Lesion on foot of patient reported on in case 1. *A*, before histamine therapy. *B*, after histamine and chlortetracycline had been given by infusion into the popliteal artery.

Case 1.—A 65-year-old patient had diabetes and coronary and peripheral vascular insufficiency. He had a large, deep, infected ulceration of the foot (fig. 1*A*) that had not improved after six weeks of therapy that consisted of the oral administration of vasodilators and antibiotics and incision and drainage of the wound. There had been no relief of pain, fever, and swelling. Micrococci cultured from the wound were sensitive to chlortetracycline (Aureomycin). No pedal pulses were present; an oscillometric reading taken on the upper half of one leg was 2, on the other leg 5. The patient received infusions of histamine and chlortetracycline into the popliteal artery. His pain was relieved after the sixth infusion. After the 12th infusion, the patient was sent home from the hospital; the ulcer was healed in six weeks (fig. 1*B*).

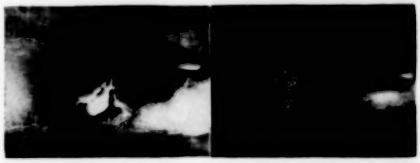

Fig. 2.—Lesion on foot of patient reported on in case 2. *A*, before histamine therapy. *B*, after histamine and erythromycin had been given by infusion into the femoral artery.

Case 2.—A 62-year-old patient with diabetes and arteriosclerosis of the femoral artery had an infected ulceration that involved the joint at the base of the first toe (fig. 2*A*). At the end of 71 weeks of treatment that consisted of the oral administration of vasodilators and antibiotics, lumbar sympathectomy, bed rest, and the use of crutches, the patient still required narcotics for the relief of pain. The oscillometric reading in the upper half of the leg was zero; there was no popliteal pulse. Micrococci cultured from the wound were sensitive to erythromycin. The patient was given infusions of histamine and erythromycin into the femoral artery once or twice a week. The pain was relieved after 4 weeks of treatment; the lesion was completely healed by the 40th week (fig. 2*B*).

SUMMARY

Responses made by patients with peripheral arterial obliterative diseases after repeated arterial infusions of histamine support the thesis that the true objective of treatment is not to release vasospasm but to give impetus to a structural dilatation of collateral vessels. Histamine, in my experience and in that of others, is the most effective agent to bring about this change, because it can cause the greatest vasodilatation and increase of blood flow in collateral vessels. Histamine when combined with antibiotics in the arterial infusion offers the best opportunity to cure infections that complicate peripheral vascular disease.

1882 Grand Concourse.

13. Mufson, I.: Diagnosis and Treatment of Neural Complications of Peripheral Arterial Obliterative Disease, Angiology 3: 392-396, 1952.

Treatment of Psittacosis.—This disease results from infection with one of the largest viruses and is almost always contracted from contact with members of the bird family. The virus is as large as some small bacteria and its reproduction can be stopped by certain chemotherapeutic agents effective against bacteria. Sulfonamide drugs are not of much value in this disease nor is streptomycin. Penicillin, however, in large doses, may, in some cases, be curative. Certain of the so-called broad spectrum drugs are even more active than penicillin. Aureomycin or terramycin have been demonstrated to have usefulness in the treatment of psittacosis and either appears to be more effective than chloramphenicol. The recommended dosage is similar to that employed in acute bacterial infections of the intestinal and urinary tracts and therapy should be continued for at least one week.—Frank L. Horsfall Jr., M.D., Chemotherapy of Respiratory Viral Diseases, *Pediatrics*, June, 1954.

TRACHEOPATHIA OSTEOPLASTICA

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and
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Tracheopathia osteoplastica is a rare disease of the trachea and bronchi characterized by growths of cartilage and bone within the wall of the trachea or bronchus that produce sessile polyps and plaques that project into the lumen and may partly obstruct it. The clinical manifestations, when present, are cough, expectoration, hemoptysis, fever, and bouts of obstructive pneumonitis. In some instances these may be severe and even fatal; in others the symptoms may be mild, and some patients with the disease have no symptoms at all. The disease was first described by Wilks [1] in 1857. Since then there have been many case reports, and Dalgaard,[2] in an excellent review in 1947, found 90 cases in the medical literature. Moersch and associates [3] in 1937 reported the first case of this condition to be diagnosed at the Mayo Clinic. Since then this diagnosis has been made at the clinic in seven additional cases, which are reported here.

REPORT OF CASES

CASE 1.—A white man, aged 66 years, registered at the clinic on May 14, 1941, complaining of a chronic cough of six months' duration that produced 8 to 10 oz. (0.24 to 0.3 liter) of foul, brownish sputum per day. Hemoptysis had occurred several times, varying from streaking to gross bleeding. The patient had lost 40 lb. (18 kg.) during this illness. The physical examination showed an emaciated, chronically ill, elderly white man. Rales were heard over the lower lobes of both lungs. A roentgenogram of the chest was interpreted as showing bronchiectasis with an abscess in the lower lobe of the left lung. A special film of the trachea showed areas of calcification in the wall of the trachea, and a bronchogram showed bronchiectasis of the lower lobe of the left lung. A bronchoscopic examination revealed a great deal of pus in the bronchus to the left lower lobe. There was marked swelling of the mucosa, with hard nodules projecting into the lumens of the trachea and both main bronchi and reducing the lumen of each of these. Biopsy (fig. 1*A*) showed inflammatory tissue with bone formation typical of tracheopathia osteoplastica. The patient was instructed in the use of postural drainage, but this was apparently of no value; he died at home two months later.

CASE 2.—A white woman, aged 57 years, registered at the clinic on July 21, 1942, complaining of a chronic cough of six years' duration that produced up to 7 oz. (0.21 liter) of yellow to brown sputum per day. This sputum was frequently streaked with blood. During the preceding nine months she had had nine episodes of chills and fever in which the temperature usually rose to 104 F. A bronchoscopic examination had been reported to show calcareous deposits in the trachea and bronchi. The results of physical examination were normal. A roentgenogram of the chest and bronchograms were also normal. A bronchoscopic examination revealed small tumors projecting from the walls of the lower third of the trachea and the left main bronchus and partially obstructing the latter. A biopsy revealed inflammatory tissue with bone formation characteristic of tracheopathia osteoplastica. The patient was instructed in the use of postural drainage and advised to see her family physician for intensive antibacterial treatment whenever she had an acute infection. Follow-up study through October, 1946, showed that she continued to have acute infections but that these were controlled by various drugs, including penicillin.

CASE 3.—A white man, aged 61 years, registered at the clinic on May 14, 1943, complaining of a chronic cough of 40 years' duration. The cough, which had been much worse for two years, produced 3 to 4 oz. (0.09 to 0.12 liter) of purulent, nonbloody sputum per day. A bronchoscopic examination had been reported to show a tumor. The physical examination revealed a few rales over both lungs. A roentgenogram of the chest was normal. A bronchoscopic examination revealed several lesions characteristic of tracheopathia osteoplastica in the trachea and right main bronchus. The lumens of the trachea and right main bronchus were not significantly narrowed. A biopsy showed only inflammatory tissue. Iodides were prescribed to liquefy the tracheobronchial secretions. The patient was not followed.

CASE 4.—A white man, aged 50 years, registered at the clinic on Sept. 23, 1949, complaining of a slight cough that had been present for many years. During the four months prior to registration he had had gross hemoptysis on several occasions. Bronchoscopy had been reported to reveal a tumor rubbing on a blood vessel. Apparently, biopsy had not been performed. The results of physical examination were normal. A roentgenogram of the chest revealed a fibrotic and calcified lesion in the upper lobe of the right lung. Tomograms of the trachea taken after a bronchoscopic examination showed thickening of the tracheal wall with several osteomas at the bifurcation. The bronchoscopic examination revealed hard tumors projecting from the wall of the trachea. They extended from 1 in. (2.54 cm.) below the larynx down into the main bronchi and varied from 2 mm. in diameter to 7 mm. by 4 mm. by 2 mm. in size. Attempts to perform biopsy on one of these tumors were unsuccessful, as the lesions were so hard that the biopsy forceps were not strong enough to break off any of the tumors. In July, 1953, the patient wrote that he was in good health and had not had any cough or hemoptysis since his examination in 1949.

CASE 5.—A white woman, aged 54 years, registered at the clinic on Aug. 16, 1951, complaining of a chronic cough of one year's duration that produced 3 to 4 oz. (0.09 to 0.12 liter) of white, frothy sputum per day. During this period there had been several acute illnesses that were diagnosed clinically as pneumonia. The patient had been found to have mild diabetes mellitus. The physical examination revealed dulness to percussion and diminished breath sounds over the lower lobe of the left lung. A roentgenogram of the chest (fig. 2) revealed an area of pneumonitis in the lower lobe of the left lung and smaller areas in the upper lobe of the left lung and the lower lobe of the right lung. Tomograms taken after the bronchoscopic examination revealed calcified lesions in the wall of the trachea and left main bronchus and narrowing of the left main bronchus. The bronchoscopic examination showed the tracheal wall to be very hard, owing to multiple plaque-like and nodular lesions that narrowed the tracheal lumen. Similar lesions were seen in the left main bronchus, the diameter of which was only 50% of normal. The right main bronchus contained no definite tumors, but its wall was very hard. Biopsy of one of the lesions revealed bronchial mucosa with areas of bone in the submucosa (fig. 1*B*). Antimicrobial therapy was recommended for the pneumonitis, but it did not control the attacks (fig. 3); the patient died at home on May 11, 1952.

CASE 6.—A white woman, aged 56 years, registered at the clinic on Sept. 4, 1951, complaining of a chronic cough of one year's duration that produced as much as 8 oz. (0.24 liter) of mucoid sputum per day. On one occasion this had been streaked

From the Section of Medicine, Mayo Clinic, and the Mayo Foundation, University of Minnesota.

Read before the Midwest Regional Meeting of the American College of Physicians, Milwaukee, Nov. 21, 1953.

1. Wilks, S.: Ossific Deposits on the Larynx, Trachea and Bronchi, Tr. Path. Soc. London **8**:188, 1857.

2. Dalgaard, J. B.: Tracheopathia Chondro-Osteoplastica: A Case Elucidating the Problems Concerning Development and Ossification of Elastic Cartilage, Acta path. et microbiol. Scandinav. **24**:118-134, 1947.

3. Moersch, H. J.; Broders, A. C., and Havens, F. Z.: Tracheopathia Osteoplastica (Osteoma of the Trachea), Arch. Otolaryng. **26**:291-293 (Sept.) 1937.

with blood. The physical examination revealed many rales over both lungs. A roentgenogram of the chest revealed extensive bilateral pulmonary fibrosis. Tomograms taken after the bronchoscopic examination showed calcified lesions in the wall of the trachea. The bronchoscopic examination revealed the presence of multiple nodules measuring about 2 by 3 by 3 mm. arising from the walls of the trachea and both main bronchi. The lesions, numbering about 15, were hard but appeared to be covered with

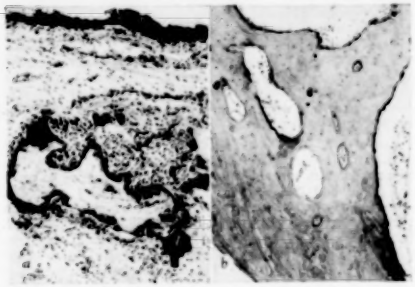

Fig. 1.—*A*, photomicrograph of tissue from an early lesion of tracheopathia osteoplastica occurring in the patient in case 1. Note the intact mucosa above the island of young bone in the internal fibrous layer of the tracheal wall (hematoxylin and eosin; × 115). *B*, photomicrograph of tissue including a plaque of mature bone that was collected from a lesion of the patient in case 5 (hematoxylin and eosin; × 100).

a normal mucosa. The bronchoscopist was unable to remove any of the tumors for microscopic study. A biopsy of the mucosa revealed only inflammatory tissue. The patient's cough persisted, and she became dyspneic after mild exertion. An examination at another clinic in April, 1952, revealed progression in the

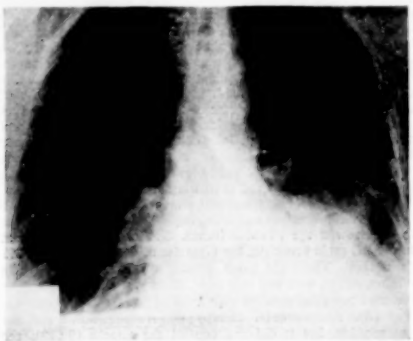

Fig. 2.—Roentgenogram of the chest of the patient in case 5 made on Aug. 17, 1951. Obstructive pneumonitis is secondary to tracheopathia osteoplastica.

nodular disease in the lungs. During an attempted needle biopsy of the lung a cardiac complication developed that required cardiac massage, which failed to revive the patient. A pulmonary biopsy taken at the time of the cardiac massage was reported to show pulmonary adenomatosis. Autopsy was not performed.

4. Jackson, C., and Jackson, C. L.: Benign Tumors of Trachea and Bronchi, with Especial Reference to Tumor-like Formations of Inflammatory Origin, J. A. M. A. **99**: 1747-1754 (Nov. 19) 1932.

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CASE 7.—A white woman, aged 67 years, registered at the clinic on March 18, 1952, complaining of a cough of six months' duration that produced small amounts of mucoid sputum. Hemoptysis had not occurred. The physical examination revealed persistent rales over the lower lobe of the left lung. A roentgenogram of the chest was normal except for calcified lesions projecting from the wall of the trachea. A bronchoscopic examination was advised, but the patient was unable to remain in Rochester to have it done. She reported in July, 1953, that her general health was good but that the cough had persisted. There had been no hemoptysis or attacks of pneumonia.

COMMENT

There are several hypotheses as to the pathogenesis of tracheopathia osteoplastica, but none of these has been proved. We consider the most acceptable to be Dalgaard's concept, according to which undifferentiated connective tissue cells in the wall of the trachea develop into cartilage cells that grow into islands of cartilage, which become partly calcified. Their invasion by connective tissue that is rich in blood vessels results in the formation of marrow cavities lined with osteoblasts, which may account for the transformation into bone. These islands may secondarily fuse with the tracheal rings but usually begin in the inter-

Fig. 3.—Roentgenogram of the chest of the patient in case 5 made on March 5, 1952. The obstructive pneumonitis is markedly increased. The patient died two months after this film was made.

spaces between the rings. A complete review of the other hypotheses of pathogenesis may be found in Dalgaard's article.[2]

According to the literature, tracheopathia osteoplastica usually does not produce any symptoms, the disease being observed incidentally at necropsy. Our experience is contrary to this, for in all seven of our cases there were symptoms and in some instances these were serious; in fact, three of our seven patients have died, two of them because of complications of tracheopathia osteoplastica. Furthermore, a search of the files of the section of pathologic anatomy of the Mayo Clinic did not reveal a single case of tracheopathia osteoplastica, and the disease is so characteristic that it could hardly have been overlooked had it been present.

Jackson and Jackson,[4] Moersch and associates,[3] Clerf,[5] and Lell [6] have all called attention to the importance of bronchoscopy in the diagnosis of tracheopathia osteoplastica. This examination led to the diagnosis in six of our seven cases. In the seventh case the diagnosis was suspected because of calcifications of the tracheal wall,

but bronchoscopic examination was refused by the patient. Bronchoscopic findings varied according to the severity of the process. In all instances there was marked rigidity of the walls of the trachea and bronchi. In the cases of early tracheopathia osteoplastica the tracheal and bronchial walls presented a beaded appearance due to the presence of numerous sessile nodules. In the cases of more advanced tracheopathia osteoplastica polypoid lesions were present, and in some instances there was extreme thickening of the tracheal and bronchial walls that was apparently due to the coalescence of sessile and polypoid nodules. Large, plaque-like areas were noted in one or two of the cases of advanced tracheopathia osteoplastica. The lesions were invariably covered by an apparently normal mucous membrane. The rigidity of the trachea and bronchi often made it difficult to pass the bronchoscope beyond the trachea into the left main bronchus. The tracheal and bronchial walls were extremely hard when touched with the bronchoscope or with forceps. In three instances we were able to obtain tissue that showed the presence of bone on microscopic examination; in the other three patients the lesions were so hard that satisfactory biopsy specimens could not be obtained. In all instances the bifurcation of the trachea was thickened, and in some of the cases the nodules were of sufficient size to produce a partial bronchial obstruction. The appearance of the trachea and bronchi is unforgettable to the bronchoscopist who has once seen the characteristic picture; however, it is difficult to describe, and efforts have been made to portray the appearance of the trachea as viewed by the bronchoscopist. Drawings of this appearance are included in the articles by Jackson and Jackson,[4] Moersch and associates,[3] and Clerf.[5]

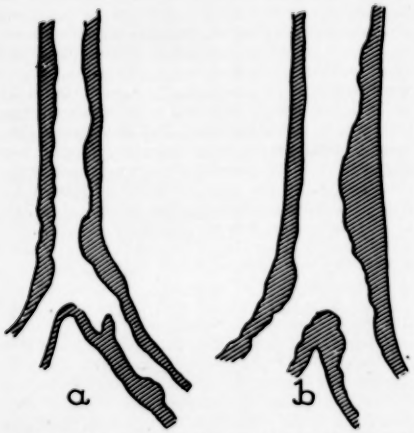

Fig. 4.—Schematic drawings from tomograms of the tracheas and main bronchi of patients with tracheopathia osteoplastica. *A* (case 5), marked narrowing of the trachea and left main bronchus caused by multiple sessile and polypoid lesions. *B* (case 4), plaque-like thickening of the left tracheal wall due to coalescence of sessile lesions.

In several of our patients tomograms of the trachea and bronchi revealed shadows suggestive of tracheopathia osteoplastica. Although these films were usually made after the diagnosis of tracheopathia osteoplastica had been made on the basis of bronchoscopic examination, they have contributed to our knowledge of this condition. The nodules do not stand out as clearly in the tomographic image as they do to the bronchoscopist. The tomogram depicts the thickening of the entire tracheal and bronchial wall, the surface of which has a beaded or scalloped appearance. At times the tomogram will show a large polyp (fig. 4*A*) or an extensive plaque-like appearance produced by coalescence of the nodules (fig. 4*B*). The tomograms also illustrate the extreme narrowing of the trachea that may occur, as in figure 4*A*.

The course of the disease seems to be quite variable; some of our patients were free of symptoms for years, and others died of complications of the disease in a short time. Apparently the degree of obstruction of the trachea and bronchi and the presence or absence of obstructive pneumonitis are of great importance in determining the outcome in any given case. No specific treatment is known for tracheopathia osteoplastica. The usual measures to prevent and control obstructive pneumonitis are advisable: expectorants, postural drainage, avoidance of all respiratory irritants, and the prompt and thorough treatment of all bouts of pneumonitis with the antimicrobial agents that are most effective against the causative organisms.

SUMMARY

Tracheopathia osteoplastica is a rare disease characterized pathologically by the development of growths of cartilage and bone in the walls of the trachea and bronchi and clinically by cough, expectoration, hemoptysis, and bouts of obstructive pneumonitis. Seven additional cases have been reported, six of which were diagnosed by bronchoscopic examination and, in three instances, biopsy. Tomograms of the trachea and bronchi have been of value in diagnosis and in studying the extent of these lesions. The cause of the disease is not known, and no specific therapy is available. Obstructive pneumonitis is a common complication and should be treated intensively with appropriate antimicrobial drugs.

Headaches.—Ninety-five per cent of headaches encountered by the physician arise from painful distention of certain branches of the external carotid artery and/or sustained contraction of ischemic skeletal muscle about face, scalp and neck. Migraine headache, atypical facial neuralgias, recurrent post-traumatic headache, and most headaches associated with arterial hypertension are included in the above categories of extracranial headache. Less commonly, headache is directly attributable to disease of the eyes, nose and paranasal sinuses, ears and teeth; and sensory ganglion, root or nerve disorders involving the face. Rarely, inflammation of cranial arteries is a source of headache—cranial arteritis. Intracranial pain-sensitive structures are sometimes also the source of headache. Space-occupying lesions (neoplasms, hemorrhage), inflammation of the meninges and distention of intracranial arteries in certain instances of vascular headache of the migraine type, in hypoxic states, by nitrites and other chemical agents, and with fever sepsis and bacteremia are examples of such causes. Other intracranial headaches are associated with diminished cerebrospinal fluid volume which may follow lumbar puncture or pneumoencephalography.—M. M. Tunis, M.D., and H. G. Wolff, M.D., Varieties of Headache and Their Mechanism, *The Medical Clinics of North America*, May, 1954.

EARLY DIAGNOSIS OF PHLEBOTHROMBOSIS WITH AID OF A NEW CLINICAL TEST

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Speculation has been endless in an attempt to determine why thromboembolism is still so prominent a cause of death. As early as 1934, John Homans [1] popularized the concept of pulmonary embolism originating in the leg veins and its prevention by venous interruption. He made the first clear differentiation of inflammatory from "bland" phlebitis. Ochsner and DeBakey [2] gave the latter the term phlebothrombosis. Homans also described a clinical test that has been helpful in establishing the diagnosis in doubtful cases. Following this lead, many studies have been made both in clinical and laboratory investigation, and numerous tests have been described. Venography was investigated and found unreliable. The advent of anticoagulant drugs served as an additional stimulus, and the persons studying the means of therapy divided; some favored surgical interruption of the venous system, and others favored the use of anticoagulant drugs. Despite all these advances, the overall incidence of pulmonary embolism has not appreciably changed in the past two decades, even with the use of anticoagulants and vein interruption procedures; some statistics even show an increase in the incidence. During this era, early ambulation has become routine, and close scrutiny by the house officers for signs of thrombosis has become a habit.

Since all this progress has been assimilated, why has the incidence of fatal and nonfatal pulmonary embolism not dropped precipitously? Is it the therapy that is lacking, or are the diagnostic facilities inadequate? Numerous additional explanations for this discrepancy have been advanced. Scrutiny of Roe and Goldthwaite's [3] statistics for the Massachusetts General Hospital showed these figures for patients routinely admitted: from 1931 to 1935, 2.36% of the patients died of fatal pulmonary embolism; from 1936 to 1940, 3.33% died; and from 1943 to 1947, 2.54% died. During the years included in the latter two groupings, bilateral femoral vein ligations were being done at this hospital on small provocation; there was still no change in the rate of deaths that were caused by fatal pulmonary embolism. These authors also showed that from 1943 to 1947, there were 92 deaths from fatal pulmonary embolism; 49 (53%) of these were without warning, despite the fact that the house officers were on the alert and extensive therapeutic programs were in progress. In Belt's series [4] of deaths resulting from pulmonary embolism, 90% of the patients on whom autopsy was done were not known to have had any thromboembolic disease. Barker's group [5] found that 85% of their patients with fatal embolism died without premonitory signs. Dehlinger and Riemenschneider [6] found that 92% of the patients on whom autopsies were later done showed no signs and symptoms requiring specific therapy. In the series reviewed by Ravdin and Kirby,[7] thromboembolism was first recognized in 74% of the patients after massive pulmonary embolism. The 12 year survey at the Charity Hospital [8] (New Orleans) showed that over 75% of patients dying of pulmonary embolism showed no leg signs; 50% of the patients who died had chest signs of some type. Zimmerman and his colleagues [9] reviewed the deaths from fatal pulmonary embolism for 17 years. These data were collected from the Michael Reese and Chicago Memorial hospitals. In this series 94% of deaths occurred in patients who were at no time suspected of having any type of intravascular clot. These figures would indicate, therefore, that significant numbers of patients have this condition without its being recognized.

CLINICAL PICTURE

Apparently the clinical signs in the patients that died without warning were negligible. No adequate laboratory test is available. Patients who have the classical phlebothrombosis may not show the following accepted clinical signs, which would help to establish the diagnosis of phlebitis: leg pain, swelling, redness, heat, increased vasomotor tone, superficial venous congestion, dilated pretibial veins,[10] tenderness on calf compression, tenderness on deep calf compression (against tibia), tenderness on deep plantar surface of foot, vessel tenderness, pain on dorsiflexion, pain on calf muscle rocking, and the cough-pain sign.[11]

De Takats [12] showed that in 20 to 25% of his cases, the first embolus was the fatal one. Classical embolic phenomena are believed to be present if there has been sudden chest pain, pain on respiration, sudden hemoptysis, rib cage tenderness, or an x-ray shadow suggestive of infarction. Since there is a very large group of cases

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Drs. Gustav E. Lindskog, Alfred Hurwitz, Courtney C. Bishop, Louis H. Nahum, and Samuel Climo assisted in the preparation of this manuscript and gave permission to see some of their patients.

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10. Moses, W. R.: The Early Diagnosis of Phlebothrombosis, New England J. Med. **234**: 288-291, 1946.

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12. De Takats, G., and Fowler, E. F.: Problem of Thrombo-Embolism, Surgery **17**: 153-177, 1945.

first diagnosed in the autopsy room,[13] the patients with few or no signs and symptoms are the ones who most urgently require surgical or medical procedures to prevent extension of their phlebitic process. In phlebothrombosis as defined by Ochsner and DeBakey, there is commonly no color or skin temperature change, no swelling, no fever, and only occasionally an ache in one limb. The diagnosis then becomes a delicate problem, based solely on elevation of temperature, pulse rate, leukocyte count, and sedimentation rate. The attending physician and the house officer must rely on the thoroughness of their examination of the lower extremities and their interpretation of these findings. This is often very difficult, and usually several members of the attending or house staff will disagree as to the diagnosis. If the house officer is armed with a test that is quantitative and that has an end point, he and his fellow house officers will always concur in the diagnosis. Such a test is available.

SPHYGMOMANOMETER CUFF PAIN TEST

For the past four years, I have used a very simple test for confirming the diagnosis in doubtful cases of phlebothrombosis and for predicting the onset of phlebothrombosis in other instances. The use of this test is superfluous when the diagnosis of thrombophlebitis is obvious. The value of this test in following surgical cases as well as those of hospitalized or invalid patients will be immediately apparent. The only equipment necessary is a sphygmomanometer. In patients suspected of having phlebothrombosis, the pneumatic cuff is placed about the calf or thigh and slowly distended; distention of the cuff should be accomplished in 10 to 15 seconds. Normally patients do not register discomfort below 180 mm. Hg over the calf or thigh. In the presence of phlebitis, the patient will complain bitterly of pain at a level significantly below the normal. At this point the cuff is immediately deflated, and the test is repeated on the other calf. If doubt exists in the examiner's mind about the patient's interpretation of pain, he need only repeat the test on the patient's arm. Most patients will tolerate 250 mm. Hg on the arm without complaint. When the sphygmomanometer cuff pain test is done as part of the physical examination, one simply proceeds from blood pressure determination to leg testing. In general, the patient is not alerted to any impending calf pain. He is watched for alteration of facial expression or a withdrawal reaction. With the first pain, the patient may withdraw by flexing his thigh.

A positive sphygmomanometer cuff pain test is recorded when there is a clear-cut patient pain response anywhere from 60 to 150 mm. Hg. This can be repeated for clarification, and the end point should be within 10 mm. Hg of the previous recording. Discomfort is registered always in the segment of extremity covered by the pneumatic cuff. The patient will usually relate to the examiner that the cuff was tighter at the strongly positive location than at the same position on the other leg, although the pressure might have been 100 millimeters less. One or two repetitions of the test without pause do not seem to alter its sensitivity or the pathological process underlying.

The sphygmomanometer cuff pain test as described above has now been done on about 350 patients, some in the hospital and some in the office. One hundred sixty-nine patients with positive tests have been classified as having primary or secondary vascular disease. The diagnoses of the diseases of the 93 patients who had primary vascular disease follow.

Thrombophlebitis		35
Superficial	18*	
Deep	17	
Phlebothrombosis		28
Varicose veins		6
Postphlebitic syndrome		12
Elephantiasis		4
Thrombosis in vena cava		1
Pulmonary embolism		7
Nonfatal	6	
Fatal	1	

* Two of these patients had thromboangiitis obliterans.

Seventy-six patients had secondary vascular disease: an intravascular clot was diagnosed clinically either at the time of the sphygmomanometer cuff pain test or subsequently. The primary conditions with which vascular disease was associated are listed below.

Parturition (ante partum)*		2
Parturition (post partum)		10
Vaginal delivery	9	
Cesarean section	1	
Surgery		10
Contusions to trunk		6
Contusions to extremities without fracture or dislocation		34
Electroconvulsive therapy		2
Amputation (disease in remaining extremity)		8
Erythema due to sunburn		1
Gout		2

* One patient had congenital hemolytic icterus.

This test has served as a screening mechanism in many cases and as a method of confirming a clinical impression in others. It has been done from one to several times daily without untoward result. It has never resulted in pulmonary embolism and has never noticeably influenced the course of the patient's disease unfavorably. In the entire series, only one patient has complained (on two occasions) that she had increased discomfort the day after the test.

Studying a large number of patients by this method would seem to indicate that false positive results occur. This may be more apparent than real, however, if we agree with Neumann [14] that 50 to 60% of adults carry thrombi in plantar or calf veins. Rössle [15] believes that 27% of people over 20 years of age have thrombi in their leg muscles. This concept is bolstered by the number of cases in which apparently minimal trauma produces thrombophlebitis or phlebothrombosis. Further support for this concept is the knowledge that phlebitis frequently starts very soon after bed rest is instituted or immediately postoperatively. False positive results probably occur in conditions producing muscle cramps, for example, pregnancy. Direct trauma to the lower extremity may also produce a false positive test; some of these patients, however, on closer scrutiny will show occult signs of phlebitis. Patients with intermittent claudication and other conditions resulting in calf tenderness should have a con-

13. DeBakey, M. E.: Collective Review: A Critical Evaluation of the Problem of Thromboembolism, Internat. Abstr. Surg. **98**: 1-27, 1954.

14. Neumann, R.: Ursprungszentren und Entwicklungsformen der Bein-Thrombose, Arch. f. path. Anat. **301**: 708-735, 1938.

15. Rössle, R.: Ueber die Bedeutung und die Entstehung der Wadenvenenthrombosen, Arch. path. Anat. **300**: 180-189, 1937.

trol test made at the beginning of their hospitalization. Marked changes in their response to the sphygmomanometer cuff pain test are of greater significance than a single observation of a postive test at a time when a diagnosis of intravascular clotting is suspected.

False negative results were not encountered in this series. In no patient who had a negative test did clinical leg thrombophlebitis or pulmonary embolism develop. One patient was seen after a classical pulmonary embolus had developed. She had a negative sphygmomanometer cuff pain test over both calves. The left antecubital space at the site of an intravenous infusion was the center of an extensive thrombophlebitic process; this was apparently the origin of the pulmonary embolus.

Certain modifications of the sphygmomanometer cuff pain test as described above are worthy of mention. The test may be applied to the thigh or to the foot as well as to the calf. The latter observations are just beginning to accumulate, but the early results of thigh testing coincide with the observations of McLachlin and Paterson,[16] who demonstrated pathologically that 73% of cases of phlebitis originate in the thigh and pelvis. I have followed patients through to a negative test over the calf only to observe a positive test still present over the thigh. Plantar phlebitis is evidenced by a positive test over the foot.

REPORT OF CASES

Case 1.—A 60-year-old white housewife struck the posterior part of her left calf on a crate on Nov. 21, 1953, while she was shopping. Ten days later she had sudden pain as though "struck by a rock in the back of the left leg." The next day she noted swelling of the left ankle, which increased as the day went on. Walking and bed rest gave her relief. Examination on Dec. 7, 1953, showed 1.5 cm. swelling of the left calf and 0.7 cm. swelling of the left ankle. Dorsiflexion caused no discomfort. A sphygmomanometer cuff pain test over the left calf produced sharp pain at 70 mm. Hg but none at 200 mm. Hg on the right calf. The patient was admitted to the St. Raphael's Hospital and given heparin and bishydroxycoumarin (Dicoumarol). Two days after bed rest was instituted, vessel tenderness was noted bilaterally. The test at this time was positive over both calves and both thighs, right thigh at 140, left thigh at 110, right calf at 120, and left calf at 80 mm. Hg. Rapid improvement was noted thereafter and continued as the patient was allowed to walk. Exhaustive search was made for occult malignancy, but none was found. The patient was discharged from the hospital in 12 days, at which time the test was positive at 160 mm. Hg on the left calf only. Anticoagulants were given while the patient was at home. When she was last seen, no swelling was present, and the test was negative throughout both legs.

Case 2.—A 72-year-old white rolling mill operator was admitted on Jan. 4, 1954, to the Derby Hospital with marked varicose veins and arteriosclerosis obliterans. A right lumbar sympathectomy was done with good results. On the fifth day postoperatively the patient complained of pain in the right leg. Examination showed a superficial phlebitis with some swelling of the right calf and right ankle. A sphygmomanometer cuff pain test was positive on the right calf at 100 mm. Hg (the cuff was not placed over the inflamed segment). The patient was given heparin and the phlebitic process was reduced. He was discharged on the 10th postoperative day; the superficial phlebitis had subsided, and the swelling had gone down. The test on discharge was still positive at 150 mm. Hg over the thigh. When the patient was seen in the office three weeks postoperatively, sphygmomanometer cuff pain was recorded at 130 mm. Hg over the right thigh and 180 mm. Hg over the right calf. The test on the left leg was negative. The remaining tenderness was interpreted as indicative of residual vasculitis, and the patient was kept under observation.

Case 3.—A 39-year-old white telephone lineman returned to the office on Jan. 29, 1954, because of pain in the left ankle of four weeks' duration. This patient had had two episodes of spontaneous superficial thrombophlebitis, one in each leg, the last occurring in November, 1951. A diagnosis of thromboangiitis obliterans was proved by the examination of the pathological specimen at that time at the Grace Hospital. The sphygmomanometer cuff pain test was 120 mm. Hg on the left calf and left thigh and negative on the right leg. No superficial phlebitis and no other positive signs were seen. Treatment with vasodilator medication and elimination of smoking resulted in gradual improvement. This patient will be seen periodically in the future.

Case 4.—A 58-year-old white housewife was operated on for very severe varicose veins at the Grace Hospital on July 31, 1952. On Dec. 11, 1953, she was seen in the office for a painful, swollen right ankle. This ankle had struck a hard object two weeks previously. The ankle appeared red and swollen, and deep calf tenderness was noted. The sphygmomanometer cuff produced sharp pain over the right calf at 70 mm. Hg. On the left calf, pain was not produced at 200 mm. Hg. The patient was admitted to the St. Raphael's Hospital, and anticoagulant therapy was given with the use of heparin and bishydroxycoumarin. Six days later the patient was discharged with the swelling gone and the test negative bilaterally. Follow-up in the office has showed no recurrence.

Case 5.—A 61-year-old white male furniture dealer was seen in 1952 for a flare-up of a postphlebitic syndrome on the left side. The patient returned on Jan. 4, 1954, giving a history of an injury to the posterior portion of the left leg three weeks previously. Soreness and swelling were present despite the use of an elastic stocking. Over the lateral aspect of the left leg a reddish nodule about 0.5 in. (1.27 cm.) square was found. The nodule was tender to touch, and the left calf measured 0.75 in. (1.91 cm.) larger than the right. There was a definitely positive sphygmomanometer cuff pain test over the left calf at 150 mm. Hg (above the level of the nodule). The opposite calf was asymptomatic at 210 mm. Hg. The patient was kept ambulatory and given vasodilator medicaments. Four days later the pain was reduced and the test negative. The patient was discharged symptom-free a week later.

Case 6.—A 69-year-old retired white man was seen on Aug. 5, 1952, because of a painful, hot, swollen right leg. Two weeks previously he had noted the onset of redness and tenderness on the medial part of the right leg. Three days later he found a "tubular" mass in the medial part of the thigh and noted the onset of ankle swelling. He had chest pain about this time with exacerbation on deep inspiration. Two years previously he had had a similar process on the medial portion of the left leg. Tenderness was elicited over the medial portion of the right thigh. Discomfort on dorsiflexion and calf tenderness were not found. Sphygmomanometer cuff distention over the calf was painful at 150 mm. Hg bilaterally. The picture reverted to normal with conservative management, and the test became negative.

Case 7.—A 20-year-old white receptionist was seen first on May 17, 1951, the day after a sprain of her right ankle. Examination showed 0.13 in. (0.32 cm.) swelling of the right calf. Dorsiflexion caused discomfort, and tenderness was present in the deep calf, sole of the foot, and the popliteal space. (The sphygmomanometer cuff pain test was not done at that time.) Smoking was stopped, and anticoagulant therapy was started. Recovery was complete by June 22, 1951. On Aug. 23, 1951, she began to have pain in the right calf. Four days later there was also some pain in the left calf relieved by assuming a recumbent position. Examination at this time showed no swelling. Dorsiflexion produced no pain, and calf tenderness was absent. A sphygmomanometer cuff pain test over the calves produced pain at 130 mm. Hg on the right and 150 mm. Hg on the left. Smoking was stopped and vasodilator medication started; the patient recovered by Sept. 13, 1951. Subsequently, there were two remissions, each lasting 10 to 14 days. Between

16. McLachlin, J., and Paterson, J. C.: Some Basic Observations on Venous Thrombosis and Pulmonary Embolism, Surg., Gynec. & Obst. 93: 1-8, 1951.

these she had attacks of temporal arteritis. The two conditions seemed to alternate with each other. Symptoms cleared by Nov. 2, 1951, the test was negative, and the patient was discharged.

CASE 8.—A 53-year-old retired nurse, weighing 275 lb. (124.7 kg.), was seen on March 13, 1953, because of constant painful swelling of both legs of two years' duration. Ten years previously the patient had a prolonged period of bed rest for a "heart ailment" and had "phlebitis" at that time. When she was seen she had pain and swelling without redness, more on the right than on the left leg. Examination showed induration with spotty tenderness on the right leg and bilateral pigmentation. Sphygmomanometer cuff pain test at that time was painful over both calves at 80 mm. Hg. The patient was admitted to the St. Raphael's Hospital, and bilateral superficial femoral vein interruption was done on March 14, 1953. There was reduction of pain and swelling. Subsequently she has had a return of the symptoms, which have been very refractory to therapy. The patient has unsuccessfully attempted to lose weight, but has derived some relief from the use of adjustable canvas leg supports.

CASE 9.—A 67-year-old white farmer had a saucerization of an osteomyelitis of the right femur on Nov. 18, 1953. Prior to discharge from the Griffin Hospital, the patient was noted to have slight swelling of the right ankle and was therefore given intermittent anticoagulant therapy. He was seen at home on Nov. 28, 1953, because of pain in the left leg (the one previously unaffected) and swelling of the right ankle. Examination showed slight bilateral discomfort on dorsiflexion. Deep calf tenderness was present bilaterally. Sphygmomanometer cuff produced pain in the left calf at 110 mm. Hg and on the right at 130 mm. Hg. The patient was readmitted to the Griffin Hospital, anticoagulant therapy was reversed, and bilateral superficial femoral vein interruption was performed. The postoperative course was uneventful. The sphygmomanometer test showed less reaction within three days and the results gradually returned to normal.

CASE 10.—A 33-year-old white male aircraft worker was seen on Dec. 28, 1953, because of a "burning pain" in the right medial part of the thigh that had been present for two to three weeks with a gradual increase in symptoms. Examination showed a patchy erythema along the right medial midthigh to the knee. This was broader and more diffuse than a lymphangitis. No swelling was found. Tenderness was present over the right femoral triangle, markedly over the right Hunter's canal, and very slightly over the left Hunter's canal. The calves showed no abnormalities, and dorsiflexion was performed without discomfort. The sphygmomanometer cuff pain test was negative over the right calf and the left thigh. Pain was elicited at 60 mm. Hg over the right thigh and at 140 mm. Hg over the left calf. The patient was admitted to the St. Raphael's Hospital, put on a regimen of bed rest, and given heparin and bishydroxycoumarin. Two days later there was swelling of the right calf with palpably thickened veins and marked tenderness on deep palpation. Following this, improvement was noted, and calf tenderness decreased and then disappeared. Progressive improvement was noted in sphygmomanometer testing. The right thigh was slightly painful at 170 mm. Hg at the time of discharge, 11 days after admission. During the patient's hospital stay, a thorough search was made for occult cancer, but none was found.

CASE 11.—A 30-year-old white engineer was first seen on May 29, 1953. Three months previously he began to have aching in the medial part of the right thigh. Redness and soreness followed, and two hard red lumps appeared. One week previously he had a "prickly sensation" in the medial part of the left arm that was followed by the appearance of redness and tenderness. Examination showed a 5.5 in. (13.97 cm.) stretch of thrombosed great saphenous vein in the right thigh. A penny-sized area of induration and thrombosis was found just above the left elbow. Sphygmomanometer cuff distention produced pain at 120 mm. Hg on the left calf and at 100 mm. Hg on the right calf. With conservative therapy the arm lesion resolved, but the right leg phlebitis jumped on two occasions to other locations. At this point the patient was admitted to the New Haven Hospital, and saphenous vein ligation was done. A specimen removed at that time was consistent pathologically with a diagnosis of thromboangiitis obliterans. Twelve days postoperatively the patient had a bout of inflammation in the left great saphenous vein that subsided in two days with conservative treatment.

CASE 12.—A 44-year-old white painter hit his right shin on a metal table on Jan. 23, 1954. After the injury the leg bled and subsequently swelled. When he was seen in the office three days later, he complained of pain for 5 cm. about the abrasion. Examination revealed 0.5 in. (1.27 cm.) swelling of the right calf, and 0.63 in. (1.62 cm.) swelling of the right ankle. Superficial ulceration 0.5 by 0.75 in. (1.27 by 1.91 cm.) in size was present over the lower one-third of the right tibia. Dorsiflexion caused no discomfort on either side. Deep calf tenderness was present, and plantar tenderness could be elicited. Sphygmomanometer cuff distention was not painful over either thigh or over the left calf. Over the right calf, however, it produced pain at 80 mm. Hg. Three days later, left calf compression produced pain at 120 mm. Hg. On Feb. 1, 1954, the right calf was positive at 120 mm. Hg, and the left calf showed negative results. Therapy consisted of ambulation, administration of antibiotics, and elastic supportive bandages.

CASE 13.—A 32-year-old Negro housewife was in an auto accident on Jan. 3, 1954. She hit her chest on the dashboard and was thrown to the floor. Both legs hurt immediately after the accident, but the next day this pain had disappeared. On examination on Jan. 4, 1954, she was having a lot of pain along the right anterior rib margin. This was increased with coughing and breathing. Examination revealed tenderness over the ziphoid process and both costal margins. Sphygmomanometer cuff distention produced pain over the left calf at 170 and over the left thigh at 140 mm. Hg. The right leg was negative to the test. Four days later there was noted tenderness over the midportion of Hunter's canal bilaterally, and testing at that time produced pain over the left thigh at 120 and over the right thigh at 140 mm. Hg. On Jan. 14, 1954, the patient made her first complaint referable to the legs. Prior to this she referred her complaints entirely to the chest wall. At that time she noted pain in the left calf and thigh and tenderness in the medial part of the calves. Examination showed left calf tenderness and vessel tenderness in the left thigh. Sphygmomanometer cuff distension at that time produced pain over the left calf at 130 and over the left thigh at 100 mm. Hg. The right thigh was tender at 180 and the right calf negative at 210 mm. Hg. On Jan. 25, 1954, three weeks after the first positive sphygmomanometer cuff pain test, there was palpable thickening in the left calf. Ten days later there was swelling of the left ankle and calf pain. Testing at that time was painful over the right thigh at 100, over the left thigh at 110, the right calf at 140, and the left calf at 150 mm. Hg. Conservative therapy only had been given. This process was still active at the time this report was written.

CASE 14.—A 62-year-old white female machine operator was hit by a car on Sept. 25, 1953. The patient landed on her right knee and right side. After this her right leg and ankle swelled, and they remained so up to Dec. 19, 1953, when the patient was first seen. Roentgenograms had been taken, and no fractures or dislocations were found. Examination showed 0.87 in. (2.22 cm.) swelling of the right calf and 0.75 in. (1.91 cm.) swelling of the right ankle by comparison with tests made on the left leg. A 1.62 by 1.25 in. (1.59 by 3.18 cm.) pigmented scar was present just below the right patella. Slight tenderness was noted just above the knee on the medial aspect of the right thigh. Dorsiflexion caused no discomfort on either side. Pneumatic cuff compression produced pain on the right thigh at 130 mm. Hg and on the left thigh at 140 mm. Hg. Both calves were pain-free at 210 mm. Hg. On Dec. 31, 1953, after vasodilator medication and elastic support for 12 days, tenderness was elicited over the lower one-half of Hunter's canal on the right. Testing was not painful on the left thigh but did show pain at 140 mm. Hg on the right thigh. On Jan. 15, 1954, pain was noted at 160 on the left thigh and at 140 mm. Hg on the right thigh. On Jan. 29, 1954, the respective readings were 120 and 80 mm. Hg. On Feb. 18, simultaneous, bilateral, complete leg venography was performed. Comparison of the venous pattern of the two legs showed evidence of deep venous pathological conditions in the right leg. This patient is still under observation.

COMMENT

When the surgical approach is elected in the treatment of phlebitis of the leg, the accepted procedure has been bilateral femoral vein ligation. This is so because it has been proved pathologically that bland thrombi exist in the apparently uninvolved extremity and very frequently are the cause of fatal pulmonary embolism. The sphygmomanometer cuff pain test is the only clinical test that substantiates these observations, for in most patients with clinically unilateral phlebitis the test is positive bilaterally, though to a lesser degree in one leg. (In doubtful cases, the entire house staff sees a particular patient and makes the diagnosis with the aid of this test.) When the sphygmomanometer cuff pain test is negative preoperatively and becomes positive after the patient has had surgery, immediate therapy is demanded. This indication is perhaps one of the greatest values of this test. Frequently, several days after the test has become positive, more overt signs of the phlebitic process will become manifest, particularly in untreated patients. Daily testing may also be used to follow the progress of the process. In most cases complete healing will be accompanied by a negative test, although the test will remain positive after other clinical signs have disappeared. Patients with obvious thrombophlebitis usually show a positive sphygmomanometer cuff pain test on the apparently unafflicted extremity.

Routine testing of office patients has also been done on a small scale. Patients with minor illnesses and with symptoms referable to other parts of the body have made up a large part of the control series. It is very interesting to note that several unexpected positive sphygmomanometer cuff pain tests were recorded. In some of these patients, subsequent examination showed calf swelling, localized deep calf tenderness, vessel tenderness, or a combination of these. Detailed examination of the legs in these cases would not ordinarily have been indicated. Studies are presently being conducted in an attempt to understand more fully the significance of these occult signs.

SUMMARY

A review of statistics from several large series indicates a continuing death toll from pulmonary embolism. In a high percentage of these cases of fatal pulmonary embolism, phlebitis was unsuspected.

A simple clinical test for detecting phlebothrombosis before other signs are present may be made. Subjectively, the sphygmomanometer cuff pain test is positive when the patient complains of pain. Objectively, this test is positive when the patient grimaces or withdraws the limb. The objective and subjective end points are close together. This test requires no special equipment and no elaborate training. It has a sharp end point.

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DELAYED OPERATIVE MANAGEMENT OF ACUTE CHOLECYSTITIS

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There are two divergent opinions in the United States regarding the surgical management of acute cholecystitis. Those with one viewpoint prefer to operate early or during the stage of acute inflammation,[1] while the others intervene only after all acute manifestations have subsided.[2] The conclusions of both are based on empirical factors such as experience, statistical analysis of results, morbidity, and mortality. Unfortunately, basic information on the causes of gallbladder disease in general and the precipitation of acute complications in the course of such disease is lacking. Statistical studies are weakened by the nonobjective, vague criteria for the diagnosis of acute cholecystitis, by the foreboding implications in such terms as gangrene and perforation of the gallbladder, and by the absence of valid statistics on the complications resulting from technical errors at operation. To some, the concept of delayed operation implies that the acute phase of the illness goes untreated. This is untrue. Active measures based on sound principles can be taken that will reverse the inflammatory process and promote rapid recovery.

The physiological considerations that should form the basis for treatment may be summarized as follows. The gallbladder is part of a complex gastrointestinal mechanism of common embryologic origin that comprises the duodenum and stomach, the pyloric sphincter and the sphincter of Oddi, the bile and pancreatic ducts, and the glands that secrete digestive juices in the stomach, liver, and pancreas. Gallbladder disease is accompanied and, perhaps, instigated by disorders elsewhere in this system. There is evidence that many instances of acute cholecystitis are associated with the diversion of pancreatic juice into the gallbladder by spasm of the sphincter of Oddi, when the pancreatic duct opens into the common bile duct. The element of pain in acute cholecystitis that is due to inflammation of the parietal peritoneum can be reproduced precisely by distention of the bile ducts after the gallbladder has been removed. This fact would indicate that operative removal of the gallbladder is an empirically successful procedure in many but not all instances and that the origin of the pain is not attacked directly. The dynamics of flow of bile, of sphincter of

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2. (*a*) Mustard, R. L., and Custer, H. R.: The Management of Acute Cholecystitis, Surg., Gynec. & Obst. **95**: 59, 1952. (*b*) Holden, W. D.; Cebul, F. A., and Loughry, C. W.: Management of Acute Disorders of the Biliary Tract, J. A. M. A. **148**: 879 (March 15) 1952.

Oddi function, of intraductal pressures, and, therefore, of intragallbladder pressure are under the control of such gastrointestinal hormones as gastrin, secretin, cholecystokinin, and enterogastrone. The formation of these hormones is associated with the presence of food in the upper gastrointestinal tract and with the passage of hydrochloric acid from the stomach into the duodenum. The autonomic nervous system probably plays a secondary role in controlling these factors.

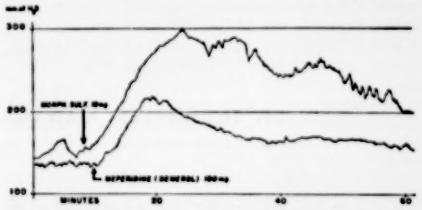
Pathological considerations that are cogent may be summarized as follows. So-called rupture and perforation of the gallbladder as complications of acute cholecystitis are not the devastating catastrophes such terms connote. In most instances initial leakage of bile is small in quantity and confined to the immediate area of the gallbladder. Omental protection against such leakage or gangrene is efficient and prompt. The finding of a discolored or leaking gallbladder after dissection and separation of adherent omentum is not evidence that the patient would have died if not operated on. The incidence of free bile in the peritoneal cavity as a complication of acute cholecystitis is so small and the condition is so innocuous with proper nonoperative treatment that prevention of this occurrence should not be the sole basis for treatment. The initial pathological changes in cholecystitis are reactions to chemical irritations resulting from functional or mechanical disorders. Bacterial contamination such as occurs in perforation of an inflamed appendix or other perforations of the gastrointestinal tract is not a factor, and no analogy can be drawn between the two types of disease.

On these premises, 116 patients in whom the diagnosis of acute cholecystitis had been made were treated by withholding operative procedures until all acute inflammation had subsided. These 116 patients were among a total of 390 patients admitted with biliary tract disease from 1948 to 1952. The diagnostic criteria of cholecystitis are ill defined. Patients with simple biliary colic were not included in this series. Evidences of acute inflammation, a tender mass in the right upper quadrant of the abdomen, peritoneal irritation, fever, and leukocytosis were present in varying degrees. In 19 of the 116 patients, a diagnosis of acute pancreatitis was made on the basis of an elevated serum amylase level; the clinical pictures in these 19 cases were in no other way distinguishable from that of acute cholecystitis alone. The following record abstracts illustrate that the differential diagnosis of these diseases is difficult and that treatment of the acute phase of both is the same.

REPORT OF CASES

Case 1.—A 38-year-old woman who had had recurrent attacks of pain in the right upper quadrant of the abdomen for two years was admitted to the medical service with pain in the epigastric region and the right upper quadrant of the abdomen that radiated to the back and to the right shoulder. She had repeated episodes of nausea, vomiting, and chills. The pain was transiently relieved by nitroglycerin. On the first hospital day the patient had tenderness in the epigastrium, the right upper quadrant of the abdomen, and the left costovertebral angle. On the second day the tenderness became generalized, and rebound tenderness was noted. The temperature rose to 101.6 F, and the leukocyte count was 26,000 per cubic millimeter. The patient was transferred to the surgical service with the diagnosis of acute cholecystitis. Serum amylase determinations at this time showed levels of 318 and 970 units per 100 cc. on consecutive days. The patient responded to the therapeutic regimen outlined below with prompt subsidence of symptoms and signs. Cholecystography done 10 days later showed a gallbladder that concentrated the medium poorly and contained numerous radiolucent calculi. Subsequently, cholecystectomy and transduodenal sphincterotomy were performed, and a cholangiogram that revealed a common passageway was made during surgery. At operation the pancreas was edematous, the tail of the pancreas was greatly enlarged, the common bile duct was dilated to a diameter of 1.5 cm., and pancreatic fat necrosis was present. The patient recovered.

Case 2.—A 64-year-old man was admitted with crampy pain in the epigastrium and the right upper quadrant of the abdomen that had been present for two days. This episode, unlike similar ones occurring during the previous three or four months, was associated with nausea and vomiting, and the pain radiated to the back. No history of food intolerance was elicited. There was spasm and moderate tenderness in the right upper quadrant of the abdomen; the temperature was 101.2 F, and the leukocyte count was 16,000 per cubic millimeter with a marked shift to the left in the differential count. During the first 24 hours of treatment the abdominal signs increased. Rebound tenderness was generalized and referred to the right upper quadrant of the abdomen, where a tender mass was palpable. By the seventh hospital day all the signs and symptoms had disappeared except the tender mass, which remained palpable. Cholecystography failed to reveal the gallbladder. One months after this attack, cholecystectomy was performed and a cholangiogram was made during surgery. The gallbladder contained calculi, was hydropic, and had a gangrenous area at the fundus. The patient recovered.



Superimposed kymograms of the resistance of the sphincter of Oddi on intramuscular administration of morphine and meperidine. Morphine produces a severer and more prolonged spasm than meperidine; the difference is much more marked when 15 mg. of morphine is administered.

INITIAL TREATMENT OF ACUTE CHOLECYSTITIS

The nonoperative regimen is based on four principles: 1. Rest of the inflamed gallbladder and the biliary and pancreatic systems is achieved by continuous suction through a nasogastric tube. This is maintained for three days or, if symptoms persist, for as long as five days. In aged and debilitated patients, in patients with pulmonary disease, and in patients who cannot tolerate a tube, earlier removal may be necessary; however, nothing is given by mouth during this period. 2. Sedation is given for pain and anxiety. Morphine should never be used for the pain of acute gallbladder inflammation; the major pain is often due to distention of the common bile duct behind a spastic sphincter of Oddi, and morphine will increase the spasm. Meperidine (Demerol) produces less spasm (see figure) and should be the only narcotic used. The pain in most patients subsides within a few hours after suction is begun, making only one or two injections necessary. Anxious patients benefit greatly from intramuscular administration of sodium phenobarbital. 3. Anticholinergic drugs are given to reduce the secretion of gastric and pancreatic juice and, therefore, the loss of electrolytes through the continuous suction, and to relax the sphincter

of Oddi, which is often spastic as a reflex to the pain from inflammation and distension of the gallbladder. Atropine has been used in the past; recently, newer drugs such as propantheline bromide (Pro-Banthine) have been used effectively. 4. Antibiotics are used to control infection. The dangers of spreading peritoneal infection and of ill effects resulting from the presence of bile in the peritoneal cavity are greatly minimized by the use of penicillin for the first three days.

TABLE 1.—*Results of Treatment of Patients with Acute Cholecystitis*

Treatment	No. of Patients			
	Treated	Improved	Worse	Died
Nonoperative				
Acute cholecystitis	97	95	1*	1
Acute pancreatitis	19	19	0	0
Operative				
Early cholecystostomy	1	1	0	0
Early cholecystectomy	2	2	0	0
None (diagnosis of acute cholecystitis not recognized)	5	0	4	1
Total	124	117	5	2

* Subphrenic abscess developed; the patient recovered.

Symptoms usually subside by the third day. After removal of the gastric tube, fat-free, clear fluids are given for one day and a soft, fat-free diet for the next day. After this a full fat-free diet is given, and the patient is encouraged to walk. It is imperative that no fats be given during the convalescent phase, for if any degree of pancreatitis is present such a diet might induce its recurrence. When cholecystographic studies are made after the patient's recovery from the acute episode, a fat meal should not be administered.

RESULTS OF THERAPY

The results obtained in the 116 patients who were managed according to the regimen described above and in 8 patients with acute cholecystitis who received other treatment are summarized in table 1. In five patients with acute cholecystitis, the disease was not recognized. A 64-year-old man with fracture of the humerus and pelvis and abdominal distension was treated for retroperitoneal hematoma; only at autopsy was acute cholecystitis revealed. A 76-year-old woman was treated for obstruction of the transverse colon by preliminary cecostomy and subsequent operation on the lesion of the transverse colon; only at this operation was the disease found to be an extension of acute cholecystitis. Cholecystectomy was performed, and the patient recovered. A 66-year-old man was operated on for an abscess of the abdominal wall that was found at operation to originate in an acutely inflamed gallbladder; simple drainage of the abscess and, later, cholecystectomy were done and resulted in recovery. A 66-year-old man and a 75-year-old man were operated on for what was diagnosed as acute appendicitis; the disease in each was found to be acute cholecystitis, and cholecystectomy and cholecystostomy, respectively, were performed. Both recovered. Emergency cholecystostomy was performed in one patient early in the course of the disease, and emergency cholecystectomy was performed in two others. These three operations were done because the clinical course was deteriorating and some intervention was obligatory. It is probable that if other extenuating circumstances had not existed these operations would not have been considered so urgent.

One of the 116 patients who were managed by measures short of operation died. This patient, a 64-year-old man, was admitted to the hospital after two weeks of abdominal pain, nausea, vomiting, and diarrhea and 15 hours of severe pain in the right upper quadrant of the abdomen. He had had asthma and hypertensive heart disease for several years, and he was taking maintenance doses of digitalis. The heart was enlarged and had a totally irregular rhythm; there was evidence of diffuse pulmonary emphysema and fibrothorax; and there was a tender mass in the right upper quadrant of the abdomen. Under nonoperative treatment the acute cholecystitis subsided, although the mass persisted. The patient had attacks of dyspnea and cyanosis, and after two weeks another attack of pain in the right upper quadrant of the abdomen occurred, which also subsided after four days. Three days later the patient became cyanotic and died. At autopsy acute and chronic cholecystitis with empyema of the gallbladder were found. The heart was hypertrophied; the lungs were bronchiectatic, with lobular pneumonia and a small pulmonary embolus; the peritoneal surfaces were clean, with 150 cc. of clear fluid in the peritoneal cavity; and the gallbladder, which was intact, was buried in peritoneal adhesions.

The only severe complication in this series was a subphrenic abscess originating in acute cholecystitis that was diagnosed three days after the patient was admitted and seven days after the onset of symptoms. This abscess may have developed during treatment or may have been present on admission. The abscess was drained, and the patient recovered after a complicated hospital course. Interval cholecystectomy was performed in 55 of these patients, in 10 of whom (18%) evidence of perforation or gangrene was encountered. In nine instances the perforation was sealed by omentum, and in the remaining patient an abscess had formed between the gallbladder and the anterior abdominal wall. Four patients were pregnant: two in the last trimester and one each in the first and second trimesters. All four were treated by early nonoperative management and responded with prompt subsidence of symptoms.

TABLE 2.—*Distribution of Patients According to Age Group*

Age	Patients	
	No.	%
Under 50	48	39
50-59	27	22
60-69	33	26
70-80	12	10
Over 80	4	3
Total	124	100

COMMENT

Many patients with cholecystitis are within that age group in which associated cardiovascular, pulmonary, hepatic, and renal diseases make operative intervention hazardous. In this series, 61% of the patients were over 50 years of age (table 2). Further, the differential diagnosis often includes coronary occlusion, hepatitis, and acute pancreatitis, diseases in which surgery is contra-

indicated. Nonoperative management of the acute phase of cholecystitis permits elective operation when these patients are in the best possible condition. It also allows adequate time to establish the diagnosis; for example, in this series 16% of the patients with a clinical picture of acute cholecystitis on admission were found to have acute pancreatitis (table 1). In our experience emergency cholecystostomy, even in patients with increasing symptoms, is very rarely necessary. Perforation is not an absolute indication for emergency operation. In this series 18% of patients operated on after subsidence of the acute phase had had perforation.

Reports of institutions where highly trained surgeons operate under the best modern conditions show that the mortality rate in early operation for acute cholecystitis is 2.7% to 6% [3]; common duct exploration is done in 6.4% to 37% of cases [4]; and cholecystostomy is performed in 11.6% to 35% of cases.[5] It is reasonable to infer that most early surgical procedures for acute cholecystitis carried out in other hospitals are done under less advantageous circumstances; in this unreported group the morbidity and mortality must, therefore, be greater. From these statistics it may be concluded that (1) the mortality of early operation is not inconsequential, (2) the extensive procedure of common duct exploration is necessary in many patients, and (3) as many as one-third of the patients may be subjected to two operations, initial cholecystostomy and secondary cholecystectomy. Interval cholecystectomy permits as extensive a procedure as is requisite to be done in an operative field in which important contiguous structures are not obscured or distorted by acute inflammation. Such a course should reduce both mortality and morbidity and preclude a second operation.

CONCLUSIONS

The definitive treatment for acute cholecystitis is operation performed during a quiescent stage of the disease. Hospitalization and active therapy are mandatory, but emergency surgery rarely is; when necessary, it should be limited to cholecystostomy, preferably with the patient under local anesthesia. The indications for early surgery should be reappraised in the light of the results of delayed operative management of acute cholecystitis.

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3. Wallace, R. H., and Allen, A. W.: Acute Cholecystitis, Arch. Surg. 43: 762 (Nov.) 1941. Glenn.[5b]
4. Lester, L. J.: Acute Cholecystitis, with Special Reference to Occurrence of Jaundice, Surgery 21: 675, 1947. Dunphy and Ross.[5c]
5. Glenn,[5b] Holden and others.[5a]

SUGGESTIONS ON PREPARATION OF MEDICAL PAPERS

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Every physician should know how to prepare a paper for presentation at a medical meeting or publication in a medical journal. Perhaps the most convincing reason for this is an altruistic one. Since writing is the only means the medical profession has of universally disseminating knowledge concerning new therapeutic concepts, medical discoveries, or clinical experience, it is the moral obligation of every physician who has made an original scientific observation, or has formulated from his own experience a new medical theory, to publish it for the information of his colleagues, and the ultimate benefit of mankind. Another good motive for writing medical articles is a purely selfish one. In addition to the sheer joy derived from effective self-expression, the physician who prepares an article on a certain subject broadens his own knowledge of that subject, for, before he can present his material in a comprehensive manner, he must have a thorough knowledge of it himself. As Sir Francis Bacon has so aptly said, "Reading maketh a full man, conference a ready man and writing an exact man." Finally, writing, which in turn requires considerable literary research, is an excellent means for the physician to continue his medical education, and this is absolutely essential if he is going to offer his patients the best available medical care.

But, before he can write, he must have something worth while to say. The "prime movers of science" are lamentably few, but this does not mean that the average mortal cannot make a useful contribution to the improvement of medical practice. Every physician has had, or eventually will have, sufficient clinical experience to provide a wealth of material for publication. He may make an original observation, encounter a unique case worthy of recording, devise a new surgical instrument, or improve a surgical technique. Despite rapid strides in clinical medicine in recent years, many medical practices are admittedly still imperfect. These provide an inexhaustible supply of subjects for research and writing. Or, for those gifted with ability to sift pertinent data from a mass of confusion and unfold it in a systematic and comprehensible fashion, the medical literature offers still another source of material, that is, the review of medical literature on a timely subject. The value of such an article, when properly prepared, is boundless.

The physician with a message to convey will want to know how to present it. Of course, only general suggestions can be given, since writing is an art acquired by reading the works of the world's great authors and by attempting to achieve similarly fluent style by actually writing. Nonetheless, there are a few fundamental rules for scientific writing, which, if followed, can make the task more pleasant.

Once the subject of the paper has been selected, it is well for the writer to formulate in his own mind a definition of this subject, since this will determine the scope of the presentation and thus help him avoid the inclination to include much irrelevant material. In determining the scope of the paper the type of audience to which it is directed should be borne in mind, for information that would interest a general practitioner might be scorned by the specialist or experimentalist.

Medical Editor, Alton Ochsner Medical Foundation.

PRELIMINARY LITERARY RESEARCH

With the subject clearly delimited and the purpose of the paper specifically in mind, the physician should next carefully examine the medical literature not only to determine whether the material has already been presented but also to familiarize himself with pertinent data that have already been published. Perusal of the literature will often be most enlightening. The reader will discover that much of what he may have considered new was actually known to the ancients. Examination of the literature thus serves two useful purposes: most importantly, it prevents needless duplication, and secondly, it broadens the reader's knowledge of his subject.

The type of bibliography required will depend on the nature of the paper to be written. If a thorough survey of a subject is to be made, the following indexes should be consulted: (1) Index-Catalogue of the Library of the Surgeon-General's Office; (2) Quarterly Cumulative Index Medicus; (3) Current List of Medical Literature; (4) specific indexes, such as those included in abstract sections of medical journals and the Excerpta Medicas; (5) table of contents of current medical journals not yet indexed; (6) card catalogue in the medical library for books, theses, and other documents on the subject; and (7) abstract journals, review journals, and annuals, such as annual reviews and recent advances. For less comprehensive articles, one of the larger medical indexes of current literature, such as the Quarterly Cumulative Index Medicus, will usually be sufficient. In such instances it is desirable to obtain all references on the subject indexed for the last five years or until an article is found that thoroughly reviews the literature and from the bibliography of which the most important earlier contributions can usually be obtained.

It will save much unnecessary labor later if, at the time the bibliography is compiled, complete references are recorded on index cards, one reference to a card. Experience has proved this to be the most expedient method, since the cards may be shuffled, added to, and manipulated in any other way. A 5 by 8 in. index card has proved most satisfactory, as it provides sufficient space for recording notes. A complete reference of an article should include the last name and initials of the author or authors, title of the article, name of the journal (usually abbreviated), volume, inclusive pages, and date of publication (including month and day when given). The complete reference should thus be written:

Briggs, J. F.: Coronary Artery Disease, J. A. M. A. **149**:345-347 (May 24) 1952.

A complete reference of a book includes the name and initials of the author or authors, title, edition, place and date of publication, publisher, volumes, if more than one, and specific page of reference; for example,

Brain, W. R.: Diseases of the Nervous System, ed. 4, New York, Oxford University Press, 1951, pp. 30-34.

References to unpublished material may be made as "Unpublished data" or "Personal communication to the author" or to an article as "To be published." Titles of foreign articles should not be translated into English but should be recorded in the original language.

ABSTRACTING LITERATURE

Each article listed in the bibliography should then be read in its entirety. As each article is read, its reference card should be before the reader so that he can record his abstract on it. At this time it is well to recheck the reference for accuracy and completeness. These cards can form the basis for a permanent file on a subject of the physician's particular interest, which can be expanded from time to time, as new articles on the subject appear. Such a file may later save much unnecessary searching for a particularly well-written article that the physician may vaguely recall having read but whose exact reference he is unable to remember. Direct quotations should always be copied verbatim and placed in quotation marks. This will eliminate the necessity for consulting the original again at the time the paper is being written if a direct quotation is to be included. Each article should be read with great care to be certain that it is correctly interpreted. Authors are frequently misquoted because the reader, in his haste to finish reading the article, has misinterpreted the author's statements.

OUTLINE

The more articles the physician reads, the more ideas he will obtain about how he wishes to present his material. By the time he has finished reading the literature, he will have formulated in his own mind a rather specific outline of his article. This outline should actually be written on paper and used as a guide when he begins drafting his paper. It will also supply him with headings and subheadings, which are desirable in any paper and particularly essential in long ones. Preparation of an outline beforehand is the only way to enable the author to write a paper that has unity, coherence, and clarity, three fundamentals of good scientific writing.

Again, the outline will, of course, depend to a great extent on the writer's own individual style, but a basic outline for clinical medical papers that can be tailored to fit the specific requirements of individual papers, placing emphasis where it belongs, would include: introduction (this includes definition of subject and purpose or scope of paper); etiology; pathological physiology; symptomatology; diagnosis, including differential diagnosis; treatment; prognosis; discussion or comment; summary or conclusions, or both; acknowledgments or footnotes, if any; references; illustrations and legends; and tables. The outline for an experimental report differs from this in that it should include: introduction; material and method; results; discussion, comment, or both; conclusions; acknowledgments or footnotes, if any; references; illustrations and legends; and tables. It should be emphasized here that the preceding suggestions cannot be rigidly followed for every paper a physician plans to write. The purpose of the paper must be borne in mind and the outline constructed accordingly. Thus, the evidence in support of the major point should be added, bit by bit and in an orderly fashion, until the point has been convincingly proved. For example, if a surgeon wants to write a paper describing a modification of a surgical technique, it would serve no useful purpose to include a discussion of such phases of the disease for which the operation was devised as the etiology, pathol-

ogy, and symptomatology. Instead, the modification should be described, after the reasons have been given for its superiority to procedures previously described.

WRITING THE PAPER

Title.—Much thought should be given to the title of the paper, since whether or not a reader decides to read the article will depend to a great extent on whether the title will arouse his interest. Moreover, indexers depend almost solely on the title in determining how to index the article. A good title is brief but informative. The best title will indicate in the fewest possible words the contents of the paper. Most authorities agree that it should be short enough to be printed on one or two lines. One editor has specified that no title should contain more than 90 letter spaces, including those between the words.[1] If a long title is essential to describe the contents of the article accurately, a short main title may be followed by a more specific subtitle. Since the title is so important, many authors do not select one until their paper has been completely written.

Introduction.—The author is now ready to begin the actual writing of the paper. He will find that the most difficult part of his task has already been accomplished. He is now fully equipped to write down his thoughts, which by this time should be well crystallized. Probably the most difficult and, incidentally, the most important paragraph in the entire paper is the first. A good introduction is brief. Considerable thought should be devoted to the initial sentence, which should be arresting enough to attract the reader's attention. The remainder of the paragraph should be devoted to preparing the reader for the forthcoming discussion.

Davidson [2] has classified the opening paragraph of medical papers into eight types: (1) historical, (2) statistical, (3) definitive, (4) expository, (5) anecdotal, (6) dramatic, (7) philosophical, and (8) apologetic. The historical, statistical, and definitive introductions are suitable for specific types of papers, such as historical or review articles, statistical analyses or papers on obscure diseases. The anecdotal and dramatic openings are extremely effective but should be employed only by the seasoned writer. The philosophical opening, so common in older medical literature, has now been relegated to such austere occasions as presidential or commencement addresses, and the apologetic opening has no place in scientific literature. Therefore, the commonest, and perhaps the safest of these for the amateur, is the expository, which provides the factual background. This type of introduction, however, requires considerable revision to give it vitality.

Body of the Paper.—The body of the paper contains all phases of the discussion except the introduction and summary or conclusions. It should unfold, in lucid language and systematic fashion, details of the introductory remarks. Again, the way in which this is done will depend on the specific subject the writer has selected and his own style of writing. The use of headings and subheadings is desirable. Not only do they make a more attractive and readable printed page, but they force the writer to confine himself to his subject and help the reader to locate in the article a specific point in which he is particularly interested.

Tabulations and graphs should be used liberally, as they frequently can tell in a few words or lines a story that might require several pages of printed matter. To be effective these should be constructed with great care. The purpose of a table is to arrange data with like characteristics in a more concise, intelligible, and vivid form than can be presented in the text. The table should be self-explanatory without reference to the text. Its title should describe accurately the data it contains. The original number of cases (not just percentages or rates) should be given, and each column should be adequately labeled. Material that has been excluded, with reasons for its exclusion, should be clearly indicated. The textual matter should not duplicate the tabulated data. Instead, the text should present the author's interpretation of the significance of the tabulations. The importance of accurate data and cautious deduction of conclusions cannot be too strongly emphasized. Since tables are usually set in different-sized type by another typesetter, each table should be typewritten on a separate sheet of paper.

The material that has been tabulated may be advantageously presented in a graph instead of the table. On rare occasions it may be desirable to present the material in a graph as well as a table. Various types of graphs may be utilized, depending primarily on the nature of the data to be plotted. Pearl [3] has classified these into graphs designed to represent frequencies or trends of things or events, to show distribution of things or events, to compare statistical constants derived from frequencies, trends, or distributions of things or events, and to aid, simplify, or avoid computations. Among the many types of graphs that may be used to accomplish these purposes are: bar, pie, spot and scatter diagrams, frequency polygons, histograms, ogive, integral, logarithmic and arithmetic curves, and nomograms. Probably the most commonly employed in medical literature is the one that utilizes rectangular coordinates; that is, one characteristic is plotted along the abscissa and another along the ordinate, the most popular of which are the bar diagram and the frequency polygon. In the construction of graphs it is extremely important to choose the proper scale, since the final curves can be greatly distorted and thus erroneous impressions may be created if the scale is incorrect.

Well-chosen illustrations not only add interest to any article but frequently elucidate textual description and provide welcome relief from blocks of printed matter. Since illustrations are costly to reproduce, most publishers will absorb the expense of only a limited number, usually five or six. For this reason, they should be carefully chosen. Publishers prefer original drawings, not photographs of them. If photographs of patients, instruments, or other material or photomicrographs are used, 5 by 7 in. glossy prints are the most suitable for reproduction in most periodicals. A good photograph of a

1. Fishbein, M.: Medical Writing: The Technic and the Art, ed. 2, Philadelphia, Blakiston Company, 1948.
2. Davidson, H. D.: Writing for Medical Journals, M. Economics **24**: 133, 1947.
3. Pearl, R.: Introduction to Medical Biometry and Statistics, ed. 3, Philadelphia, W. B. Saunders Company, 1940.

lesion should focus attention on the area to be illustrated, with only enough of the remainder of the patient's body to orient the viewer and nothing in the background to distract attention from the lesion. Photomicrographs should be clearly focused, and the magnification should be indicated in the legend. A unit of length should be included in every full-length photograph of a patient, as well as in pictures of specimens, to give the viewer an idea of the actual size of the object. The position of the illustration in the text should be indicated by a figure number. On the reverse of each illustration should be written lightly in pencil its figure number, the title and author of the article, and an indication of the top of the illustration. These should not be written in ink or heavily in pencil, as such marks may penetrate the paper to mar the picture. This information may also be typed on a separate piece of paper and pasted on the back of the illustration, with rubber cement preferably since material fixed with it can be easily peeled off without disfiguring the illustration. A legend, or brief description or identification of the illustration, should be written for each figure. All legends should be typewritten on a separate sheet of paper rather than on the back of the illustrations, since these are handled by the typesetter whereas the illustrations are turned over to the engraver.

SUMMARY OR CONCLUSIONS

Perhaps as important as the introduction is the summary or conclusions. Not every article is conducive to summarizing or deduction of conclusions, although a few may require both. Some, such as descriptive or review articles, should preferably be summarized, whereas others, such as experimental reports or theoretical considerations require conclusions. The simple case report, or description of an instrument, is usually so brief that it rarely need be summarized.

The summary should reiterate briefly the most pertinent facts contained in the body of the paper and is usually written in paragraph form. Conclusions, on the other hand, are usually enumerated and are deductions drawn from experimental or theoretic observations based on evidence presented in the body of the paper.

There is a growing pernicious tendency in the current literature to append the outline or table of contents of the paper and label it as a summary. Such material is meaningless. A good summary tells the reader briefly the important points that have been made in the body of the paper. Much time should be devoted to its preparation. As is well known, many physicians read this section of a paper first to determine whether they want to read the entire article. This is the author's opportunity to seduce his reader.

BIBLIOGRAPHIC CITATIONS

In all scientific literature it is necessary to indicate the authority for a statement, observation, or fact that the reader might doubt. In addition, the major sources of specialized information should be cited. These are usually indicated in the text by a reference number, the complete references being appended on a separate sheet at the end of the article.

There is a difference between a bibliography and literature cited. A bibliography, which is more comprehensive in scope, consists of a compilation of the literature on a specific subject and is usually arranged alphabetically according to author or numerically as the references appear in the text. Literature cited, on the other hand, includes only a list of references specifically documenting the text. Unfortunately, some medical periodicals fail to make the distinction between the two. In most articles it is merely necessary to cite the literature referred to in the text.

Since each medical publication has its own style for citing references, before these are arranged it is well to consult the journal for which the article is being prepared. If at the time the bibliography is compiled the complete references are recorded, all information needed to list the references used in the paper will be readily available. Accuracy is essential in preparing this list. Undoubtedly, everyone has had the frustrating experience of trying to locate an article whose reference was obtained from the bibliography of another article, only to learn that the reference is so inaccurate that he is unable to find it.

Of course, no article should be included in the bibliographic citations that the author has not himself read. It is tempting to quote a citation made by another author, but this is a dangerous practice, because if the author has misinterpreted the previous writer, as is frequently the case, he is helping to perpetuate that mistake. Moreover, it is dishonest because it gives the reader the impression that the author has actually consulted the original. If it is necessary to cite a work referred to by another author and for some reason the original cannot be consulted, the secondary citation should be listed in the references in the following manner:

Salzer, H., cited by Elliott, G. B., and Evans, H. S.: Peptic Perforation of Meckel's Diverticulum, Ann. Surg. 133:127-131 (July) 1953.

ACKNOWLEDGMENTS

Most editors of scientific journals discourage notes of acknowledgment to persons who have assisted in the preparation of a paper. Persons who have made a major contribution should, of course, be included in the authorship. If an acknowledgment is considered absolutely necessary, it should consist in a brief expression of gratitude to the person for the specific service rendered. Acknowledgments usually appear as footnotes but sometimes are placed at the end of the article.

STYLE

The first rough draft of a paper may be likened to the clay used by the Leeds' artists to mold their pottery. The more it is molded, the more artistic it will become. Most great writers revise their material many times. Harvey Cushing made as many as eight revisions before submitting a paper for publication, and Herbert Hoover, who is said to be still dissatisfied after as many as 12 revisions, is known to continue revising up to the moment before delivering a speech. As one editor [1] has advised, "Write and rewrite; rewrite again and then revise." No matter how well edited a paper is, another revision can always improve it.

The simplest way to revise a paper is to have a specific objective in mind during each revision. For instance, the paper should be read first for organization, then for accuracy and consistency of content, and finally, for clarity, conciseness, sentence structure, grammatical construction, and phraseology. After these points have been carefully considered, a final reading will determine whether the article reads smoothly. It is well to postpone this final revision until an interval of several weeks has elapsed, because this will enable the author to look at it with renewed interest and a freshly critical eye.

From these revisions will emerge the author's own distinct style of writing. The only secret of style, as Matthew Arnold once said, is to "have something to say and say it as clearly as you can." The best medical papers are the ones that are most simply written. Clarity, unity, and coherence, with emphasis in the right direction, combine to make pleasing style. Brevity and accuracy are also virtues of the well-written paper, but the latter should never be sacrificed for the former. No specific length can be assigned to a medical paper, but as some physician once said, "A medical paper should be like a lady's dress—short enough to be interesting but long enough to cover the subject."

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CLINICAL NOTES

ACUTE APPENDICITIS WITH INTESTINAL OBSTRUCTION

Joseph A. Buckwalter, M.D., Iowa City
and
Monte Modlin, M.B., Ch.B., London, England

Obstruction of the small intestine is a not infrequent late sequel of acute appendicitis. The obstruction results from the appendix being fixed transversely across the terminal ileum by the fibrous adhesions that may follow the acute inflammatory process. In contrast, it rarely occurs during the acute stage of appendicitis. Equally rare is mechanical obstruction in the patient with a perforated appendix and early generalized peritonitis. A review of relevant literature provides support for these statements.[1] The case report that follows is of interest in this regard.

REPORT OF CASE

A 64-year-old woman was admitted to the hospital with the chief complaint of constant abdominal pain with intermittent cramps. Two days previously she had been seized with sudden severe pain in the hypogastrium that lasted about 15 minutes and was cramp-like in character. This pain recurred and persisted in the lower part of the abdomen. She continued to experience short episodes of severe cramps superimposed on the constant pain. The pain did not radiate. It persisted as described and was still present on admission. Vomiting occurred for the first time the morning of her admission. There had been no bowel movement or passage of flatus from the onset of her symptoms. Bowel function had always been regular and normal in all regards. A history of a previous similar illness could not be elicited. There were no symptoms suggestive of urinary or biliary tract disease.

Examination revealed an acutely ill, pale, elderly, moderately dehydrated, white woman. The temperature was 100.4 F, pulse 108 per minute, respirations 24 per minute, and blood pressure 170/100 mm. Hg. The tongue was dry and furred. There was moderate abdominal distention with generalized tenderness that appeared to be most marked in the left lower quadrant. Guarding with marked bilateral rectus muscle spasm was noted. Rebound tenderness was elicited everywhere in the abdomen. Peristalsis was present with bursts of high pitched sounds. Rectovaginal examination showed tenderness anteriorly and laterally with no other abnormalities being noted. The remainder of the physical examination showed no additional significant positive findings.

The hemoglobin was 16 gm. per 100 cc., leukocyte count 7,000 per cubic millimeter, and urinalysis was normal. Blood chemistry studies showed serum chlorides 101 mEq., sodium 130 mEq., potassium 3.9 mEq., and a blood urea of 45 mg. per 100 cc. In figure 1, the roentgenogram of the abdomen in the supine position

Fig. 1.—Roentgenogram of the abdomen with the patient in a supine position.

shows the distended loops of small bowel in the right lower quadrant. In the upright film a few fluid levels were noted. These findings were thought to be compatible with an early obstruction of the intestine. Our clinical diagnosis was generalized peritonitis with mechanical obstruction of the small intestine. It was decided that immediate exploratory laparotomy was indicated. Preoperative preparation included the intravenous administration of 1,500 cc. of isotonic sodium chloride solution and gastric suction with a Ryle tube. Four hundred cubic centimeters of foul-smelling, dark fluid was aspirated.

From the Department of Surgery, Postgraduate Medical School of London.

Dr. Buckwalter is now in the Department of Surgery, University of Iowa Hospitals.

1. Jennings, J. E.; Burger, H. H., and Jacoby, M.: Acute Appendicitis: A Clinical and Pathologic Study of 1,680 Consecutive Cases, Arch. Surg. **44**: 896 (May) 1942. Tashiro, S., and Zinninger, M. M.: Appendicitis: A Review of 936 Cases at the Cincinnati General Hospital, ibid. **52**: 545 (Nov.) 1946. Thieme, E. T.: Appendicitis: A Ten Year Survey: 1935 Through 1944, ibid. **50**: 514 (Sept.) 1949. Wevill, L. B., and Wallace, H. L.: Acute Appendicitis: A Statistical Survey of 8,000 Cases, Edinburgh M. J. **41**: 557 (Oct.) 1934. Wilkie, D. P. D.: Appendicitis, Ann. Surg. **100**: 202 (July) 1934.

After the induction of general anesthesia, a low right paramedian incision was made. On incising the peritoneum, frankly purulent fluid was encountered. A grossly dilated loop of ileum was noted. It was readily determined that there was a point of obstruction just proximal to the cecum. At this point the acutely inflamed appendix was stretched tightly across the ileum effectively obstructing it. The tip of the appendix was adherent to the posterior peritoneum in relation to the obstructed ileum. A point of perforation was seen near the base of the appendix (fig. 2). The intestine proximal to the point of obstruction was edematous and dilated, measuring about twice its normal diameter; that distal to the obstruction was collapsed and appeared to be normal. There was nothing to suggest strangulation or gangrene of the involved loop. The obstruction was readily relieved by appendectomy. The appendical stump was easily inverted with a purse string suture at its base. This area was drained by a soft rubber tube brought out through a small stab wound in the right flank. The wound was closed in layers. Postoperatively the patient was maintained by intravenously administered fluids for the first three days; penicillin and chlortetracycline (Aureomycin) were administered. By the fourth postoperative day, the patient was afebrile, there was normal peristalsis, and fluid diet was started. The blood cell count and blood chemistry findings were normal. After a continued uncomplicated course, the patient was discharged from the hospital on the 11th postoperative day. Three weeks after operation the patient was asymptomatic, eating well, and gaining weight, and the wound was well healed with no evidence of infection.

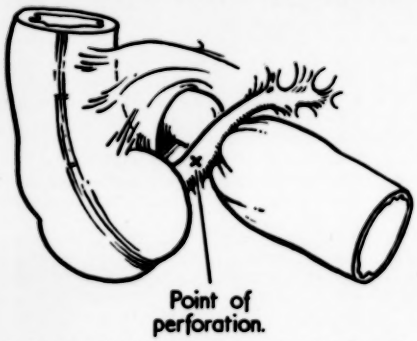


Fig. 2.—Diagram showing the terminal ileum obstructed by the appendix.

In the pathological study, the appendix was observed to be swollen toward the tip and covered with a fibrinous exudate; inspissated feces were present in the lumen, and, near the tip, the wall appeared to be necrotic. Microscopic study confirmed the diagnosis of acute suppurative appendicitis with several areas of gangrene.

COMMENT

The preoperative findings were those of peritonitis in a patient showing symptoms and signs of mechanical obstruction of the small intestine. Marked diffuse abdominal tenderness, rebound phenomena, bilateral rectus spasm with muscle guarding, tachycardia, and the prostration pointed to peritonitis. The character of the pain, no bowel movement for two days, vomiting starting the last day, active to hyperactive bowel sounds, and the suggestive roentgen findings indicated an obstruction of the low part of the small intestine. At operation the appendix was the point of obstruction with distended edematous proximal intestine and collapsed normal-appearing distal intestine.

A NEW, SIMPLE, AND PRACTICAL METHOD FOR CONTROL OF FLUIDS USED IN AEROSOL THERAPY

Edward H. Kopf, Buffalo

One of the greatest drawbacks to the application of aerosol techniques to medication and experimentation is the impractical method in use today for controlling the feeding stream of fluids into nebulizers. These systems are difficult to regulate, demand constant observation; they are untidy and wasteful of expensive medicaments. There is a real place in medicine, both experimental and therapeutic, for a new and simpler system. The system outlined below has been tested and proved in experiments in which a wide range of fluids of different viscosity were used. In one such experiment three nebulizers were put in operation for eight-hour periods daily, for a total of 1,440 hours without breakdown. The supply of air pressure was turned on in the morning and off in the evening. No other attention was necessary except refilling the fluid reservoirs. Following is an outline of the method and an explanation of the physical principles that allow it to operate.

The system consists of two tubes leading from a reservoir into the well of the nebulizer (see figure). Both tubes are filled with the same fluid as is in the reservoir. When the reservoir is inverted so that the two-hole stopper is down, the fluid runs out of one of the tubes into the well of the nebulizer and air rushes up the other tube; however, since the openings of the tubes are placed so that both will be below the desired fluid level in the nebulizer well, it is only a fraction of a second until both of these openings are "under water."

As soon as this happens no air can return up either of the tubes; a partial vacuum builds up in the reservoir, and the escape of fluid is halted. In this way a system in static equilibrium is established. This system can now be allowed to stand indefinitely "as is."

MECHANISM

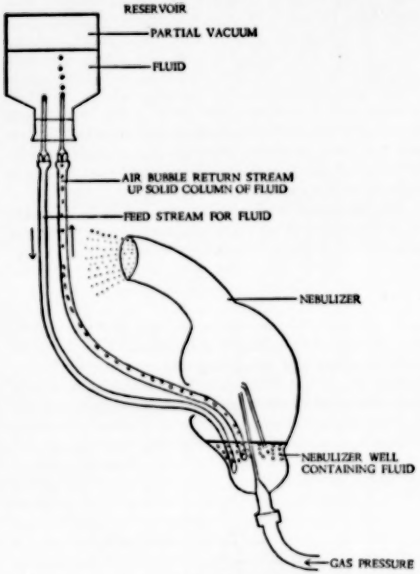
When the air stream that operates the nebulizer is turned on, the unit goes into operation and tiny air bubbles are formed near the upper part of the fluid in the nebulizer well. These air bubbles will enter the mouth of the higher tube and float up the solid column of fluid, creating an air bubble return stream. On reaching the reservoir, this air cancels part of the partial vacuum and allows some of the fluid to escape through the other tube, which becomes the feed stream. The system thus becomes one of dynamic equilibrium.

When the air supply to the nebulizer is shut off no new air bubbles are formed within the fluid in the nebulizer well to rise in the air bubble return stream and the system automatically stops. Again a partial vacuum forms and no further fluid can escape, so that the static equilibrium is reestablished. Merely turning on or off

From the University of Buffalo School of Medicine.

the nebulizer air supply automatically starts or stops the flow of fluid from the reservoir into the operating unit. No clamps or valves are needed. Nothing is spilled; nothing is wasted. The system can be shut off and left standing as it is until needed again. To start it one turns on the air and it goes into operation automatically.

When the level of the fluid in the nebulizer well is too high the bubbles suspended in the working fluid float above the gas bubble return stream opening, preventing further return of air to the reservoir. The partial vacuum is increased, and the outflow is temporarily reduced until the level of the fluid in the nebulizer well is again lowered. When the level of the fluid in the nebulizer well is too low, large bubbles of air enter the opening of the gas bubble return stream tube and rush up to the reservoir, allowing larger amounts of fluid to return to the operating unit. By this automatic system, waste and spillage are prevented, and it is not necessary to constantly watch or regulate the unit.



Mechanism for control of fluids used in aerosol therapy.

The amount of material suspended in aerosol is dependent on the rate of flow of the fluid out of the reservoir into the nebulizer well. This is automatically controlled by the rate of flow of air into the nebulizer, since it is this that determines the number of bubbles formed in the fluid in the nebulizer well as well as the amount of fluid from the well that is suspended in aerosol mist.

MATERIALS NEEDED

Any suitable bottle can be used for the reservoir; 500 cc. blood bottles are convenient since they are readily available and designed to be suspended upside down. Two-holed stoppers of proper size are available, and the bottles are graduated, permitting observation of the rate as well as of the amount of fluid administered. Tubing for the air bubble return stream and the feed stream can be of any convenient size and material. Glass tubing, rubber tubing, and the clear plastic tubing from intravenous drip sets have been used. The value of the clear tubing is primarily psychological. Since it allows visualization of the column of air bubbles rising in the return stream, it assures patients and their relatives that this stationary, hissing contraption is actually delivering the desired material into the aerosol.

The nebulizer used to form the aerosol mist can be any of the popular models in glass or in plastic as long as it has a fluid well and some orifice by which the two tubes can be inserted into the well. Other considerations are expense and durability of the nebulizer. The initial cost of the glass model is low. It is quickly and easily adapted to this system, yet these models are fragile precision instruments and, once they are plugged, are difficult to clean. The plastic models are initially more expensive and require some modification. To put them into operation two holes must be bored in the side of the well and two plastic tubes fixed into the well at the proper height with "model cement." The plastic tubes are available from the ends of intravenous drip sets.

A major advantage of plastic models is durability. They can withstand considerable abuse by inexperienced personnel. In addition, if one of these units is plugged by foreign matter it is a simple procedure to drill a tiny hole directly in line with the plugged capillary tube and insert a wire to clean it without worry about damaging the unit.

The air supply to run the system can be any convenient source; however, since most patients needing this type of medication also need oxygen therapy, that oxygen itself, flowing at a rate of 7 to 8 liters per minute, can be used.

34 Norwalk Ave. (16).

DIAPER CARE IN NURSERIES

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and
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The problem of control of so-called "epidemic diarrhea" in nurseries for newborn infants and in nurseries for sick infants is quite unsolved. The causative organism is not surely known, and its mode of transmission from patient to patient is undetermined. Whatever is revealed by future studies, it is obvious that prevention of the spread of enteric organisms will always be of prime importance. The care of fecal excretions and the laundering of diapers is a very great problem in any nursery or infant ward, and the usual programs, if safe, are both expensive

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This study was supported by a grant from the A. B. Brower and E. R. Arn Medical Research and Scholarship Fund, University of Michigan.

and elaborate. The problem of the preliminary removal of the gross fecal material from diapers before laundering is itself disagreeable, expensive, and dangerous, since all manual techniques involve some degree of splashing and increased risk of spreading disease by droplets, even if carried out at some distance from the nurseries. The number of diapers that must be purchased by an institution is enormously increased by the various steps in collecting and cleaning them due to the time intervals in moving the diapers from the wards to a distant laundry and back again. The use of a central laundry for linen from all parts of a general hospital causes increased risk avoided only by preliminary sterilization.

The purpose of this paper is to report a simple and successful experience with the use of a pair of ordinary home automatic washing and drying machines for the care of diapers without preliminary removal of feces. This experiment was carried on in a room adjacent to the infants' wards so that the whole process was separated from all other laundry problems of the hospital and was very simple and economical. Bacteriological control of the laundry project was carried out only to the point of insuring that sterility was obtained. It was not the major purpose of this study to make elaborate studies of the killing of bacteria during the process of cleansing diapers.

TABLE 1.—*Results of Bacterial Cultures of Grossly Soiled, Unsterile Diapers After Regular Washing in an Automatic Washer*

Batch *	Source of Water Sample for Culture †	Water Temperature, F	Result of Culture ‡
1	Rinse	140	No growth
2	Outlet	140	No growth
3	Outlet	142	No growth
4	Rinse	138	No growth
5	Outlet	110	No growth
6	Rinse	141	No growth
7	Rinse	141	Coliform organisms
8	Rinse	110	Coliform organisms
9	Outlet	110	Coliform organisms
10	Outlet	148	No growth
11	Outlet	150	No growth

* Each batch contained 25 diapers.
† Water samples were collected before automatic washer was opened.
‡ Cultures were done on Bacto SS and MacConkey's agar.

MATERIALS AND PROCEDURE

A standard home automatic washer and dryer were purchased and installed in utility quarters adjacent to an infants' ward of University Hospital. This ward consists of four rooms and 34 bassinets and cribs. All children in this section were under 2 years of age, and approximately two-thirds of them were between the first and second year. This is not a nursery for newborns. The children were hospitalized because of the usual reasons for admittance to a children's hospital—acute illness, congenital anomalies, and problems for diagnosis. Diarrhea was occasionally seen during the time the diaper washing project was being conducted, but no epidemic was present.

Diapers were removed from infants and, without any rinsing, were dropped into a covered can that contained either nothing but the soiled diapers or a solution of one of three germicides. Of the three germicides used, Watkin's solution, containing a mixture of creosols (*o*-phenylphenol, 2-chloro-4-phenylphenol with soap, isopropyl alcohol, 20%, and water, 63%) in a dilution of 6 oz. per gallon of wash water was most satisfactory for sterilizing the diapers and removing the odor from them. The other two disinfectants used were benzalkonium (Zephiran) chloride and benzethonium (Phemoral) chloride.

For convenience in running the washer, diapers were collected as they were removed from the infants, placed in cans, and covered by a germicidal solution, which also acted as a deodorant, until a full washer load accumulated. Several studies were made to determine the sterilizing effect of different germicides in which the diapers were immersed for different periods. These will not be reported in detail here. It is sufficient to say that a convenient germicide is Watkin's solution in which it was discovered that sterility occurred before 12 hours' submersion. The exact time was not determined, but the diapers were not kept in the solution longer than was necessary to accumulate a washer load, the main purpose of this solution being to keep the diapers in an odor-free manner until a load was collected. It was the general experience, however, when tested that much of the time the diapers were sterile after being immersed for two hours in this solution even though considerable amounts of feces were present.

The automatic washer was used exactly as it would be in the home, being set for maximum washing action as would be employed for heavily soiled clothing. A preliminary rinse in the washer with warm water, 100 to 110 F, was employed, followed by a regular hot (140 F) 15 minute wash with commercial powdered laundry soap, and then by three rinses and spin-dry action. The diapers were then transferred in the moist state to the gas-fired drier, and the drying was completed in 30 to 40 minutes. It was found that the home-sized automatic washer washed 25 diapers at a time with ease and would do 30 (table 1). Above this number per load, however, evidences of incomplete cleaning were encountered.

Cultures of the diapers were taken after the washing and again after the drying process. The cultures at the end of washing were performed as follows: The machine was opened just enough to insert a long sterile forceps to seize one diaper and drop it into a sterile covered porcelain jar containing 8 oz. of sterile isotonic sodium chloride solution. This covered container was tilted gently several times and allowed to stand for half an hour, being tilted every few minutes so as to assure the thorough penetration of the solution through the diaper. Following this, suitable amounts of the solution were removed with full bacteriological precautions and streaked on MacConkey's bile salt, Bacto SS, or chocolate agar mediums. Cultures of the dried diapers were done in a similar manner, the dryer being opened just enough to remove, with sterile forceps and under good bacteriological technique, a dried diaper that was then dropped into the sterile isotonic sodium chloride solution in a sterile container and treated exactly as described above. Bacterial studies were made of the effect of preliminary soaking of the unrinsed diapers for 12 hours in three commonly used germicides. As stated earlier, Watkin's solution was the most satisfactory. As can be seen, the data indicate sterility after the drying process, although

some growth occurred on the MacConkey's medium after the third rinse before the final drying was carried out (table 2).

COMMENT

The problem of economy was not given primary consideration in this study, but some comment is worth while. It was found that all washing, drying, and folding of diapers ready for reuse was done by one ward maid in one eight hour shift for a ward housing about 20 to 30 infants. This work did not require all of the maid's time during the eight hours; she did other work. To compare with this, however, we have no data as to the man hours of nursing and auxillary forces required to move diapers from such a ward to a laundry, remove fecal material in the usual way, launder them, return them, and, more important, keep track of the number, as well as to put them through a preliminary autoclaving sterilization as is now done in our main laundry before the laundry attendants handle them. It seems obvious, however, that a great many working hours are saved. Some comment on the number of diapers is also important.

TABLE 2.—*Results of the Combined Washing and Drying Procedure on Grossly Soiled, Unsterile Diapers**

Date	Total No. of Diapers	Result of Culture After 3rd Rinse †	Result of Culture of Dried Diapers
9-14-48	147	+	No growth
9-15-48	140	+	No growth
9-16-48	144	+	No growth
9-17-48	189	+	No growth
9-21-48	178	+	No growth
9-22-48	190	+	No growth
9-23-48	176	+	No growth
9-24-48	176	+	No growth
9-28-48	218	+	No growth
9-30-48	190	+	No growth

* In each instance, 1½ oz. of soap was used for each washer load of diapers and the temperature of the wash water was between 105 and 135 F. Increase of water temperature to 140 F resulted in sterility after washing 80% of the time.

† Cultures were done on MacConkey's bile salt agar and allowed to stand 48 hours.

The diapers removed from babies during the forenoon would be available for use again in the same ward that afternoon. The total number of diapers stored in the ward for use of the babies needed to be only a little greater than the daily supply for the same number of babies. Opposed to this, we must comment on the huge supply of diapers necessary in any fairly large institution where babies are cared for in the regular way. In general, it can be stated that one day's supply of diapers must be in reserve; one day's supply in transit to the laundry; one day's supply actually being laundered; and one day's supply in transit back again. Thus, at least four times the daily requirement must always be in circulation. We have no data as to the number of diapers actually lost (or perhaps stolen) or used for other purposes in the long and involved process of the usual hospital routine nor do we have data as to the time taken by various attendants in counting and keeping track of the diapers available, but we are sure both items are great in any institution.

SUMMARY AND CONCLUSIONS

Our studies demonstrated that home-sized, relatively inexpensive, automatic laundry equipment can be used successfully to clean and sterilize unrinsed diapers. This fact has some significance, we believe, in relation to present thinking about the desirability of having newborn and infant nurseries divided into small, independent units. The need for isolation of sections of newborn and other infant nurseries arises so often that the availability of a quick, safe means of handling the diapers undoubtedly has merit. For the small hospital, with fewer than 50 bassinets and cribs, the diaper handling problem can be solved safely and satisfactorily with a simple three-step process of handling diapers that renders them bacteriologically sterile and quite clean and odorless. These steps are: 1. Remove diaper from infant, drop diaper, without rinsing, into a covered can containing enough Watkin's solution (diluted 4 oz. to a gallon of water) to completely cover the diaper, and allow it to stand not less than two hours. 2. Wash diaper in automatic washer that rinses, washes with soap, and rinses three times. 3. Dry diaper immediately in an automatic dryer.

COUNCIL ON PHARMACY AND CHEMISTRY

The following abstract of recent nomenclature decisions of the Council is authorized for publication.

R. T. STORMONT, M.D., *Secretary.*

NEW GENERIC AND BRAND NAMES RECOGNIZED BY THE COUNCIL

The Council collaborates with manufacturers in the selection of generic and brand names for marketed drug preparations presented for acceptance and also for new products still under development or clinical trial. The last report on such names appeared in THE JOURNAL, Aug. 14, 1954, page 1425.

The following abstract lists the generic designation, the chemical name when necessary for information, and the brand name or names simultaneously recognized for the stated firms. In general, a generic name should bear recognizable relation to the chemical name and conform as closely as consistent with brevity and practicality to existing systems of scientific nomenclature. The chief requirement for a brand name is that it should not be therapeutically suggestive.

The listing of a brand name is not to be construed as indicating Council acceptance of the product itself. Products accepted for inclusion in New and Nonofficial Remedies are announced separately.

HYDRABAMINE PENICILLIN G for N,N'-bis-(dehydroabietyl)ethylenediamine dipenicillin G with lesser amounts of dihydroabietyl and tetrahydroabietyl derivatives: Compocillin (Abbott Laboratories)

HYPHYLLINE for dihydroxypropyltheophylline: Neothylline (Paul Maney Laboratories, Inc.)

IOPHENOXIC ACID for α-(2,4,6-triiodo-3-hydroxybenzyl)butyric acid: Teridax (Schering Corporation)

ISOFLUROPHATE for diisopropyl fluorophosphate: Floropryl (Sharp & Dohme, Division of Merck & Co., Inc.)

LENTE INSULIN for a suspension of zinc insulin crystals and amorphous insulin: Lente Iletin (Eli Lilly and Company)

MEPARFYNOL for 2-ethinylbutanol-2

PENTAPHONATE: Claraphos (Ernst Bischoff Company, Inc.)

POLIOMYELITIS IMMUNE GLOBULIN (HUMAN) for a preparation of gamma globulin primarily assayed for its content of poliomyelitis antibiodies in accordance with standard procedures licensed by the National Institutes of Health

POLYMONINE for a formaldehyde polymer of N-methylhomoanisylamine

CRYSTALLINE TRYPSIN for a highly purified preparation of that enzyme as derived from mammalian pancreas glands: Tryptar (Armour Laboratories)

WARFARIN (SODIUM) for 3-(α-acetonylbenzyl)-4-hydroxycoumarin and its sodium salt: Coumadin (Sodium) (Endo Products, Inc.)

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VIRAL ETIOLOGY OF LEUKEMIA

Ever since Ellermann and Bang[1] demonstrated in 1908 that chicken lymphomatosis could be transmitted by filtered extracts, it has been suspected that in other species also, including human beings, leukemia and allied diseases may be caused by transmissible viruses. Fever, so common in acute lymphomas, as well as spontaneous remissions in the course of this disease in humans, are consistent with the viral concept. The main difficulty in accepting the infectious concept of leukemia, however, has been the well-established observation that in human beings, as well as in animals, leukemia is not communicable from one host to another, at least not in a manner observed in other infectious diseases. For that reason, viral theories of leukemia, previously advanced, could not be sustained and were only of passing interest.

Gross,[2] of the Veterans Administration Hospital, Bronx, N. Y., suggests, however, that the viral concept of leukemia could be approached from a different point of view, assuming, as a working hypothesis, that oncogenous viruses (including those causing leukemia and allied diseases) are transmitted, in an inactive form, from one generation to another, directly through the germinal cells, as egg-borne infections, causing symptoms of disease only occasionally. These individually distinct viral agents, some potentially capable of causing leukemia and others able to cause different malignant tumors, would usually exist in an inactive form, frugal and moderate in their requirements and causing no apparent harm to their carrier-hosts. Occasionally, however, prompted by as yet obscure but presumably varied trigger stimuli, these hitherto masked agents may change into formidable pathogens, causing then rapid multiplication of cells harboring them, resulting in the development of leukemia or another malignant new growth (according to the individuality of the particular agent carried), and thereby sealing the fate of their hosts. Since, however, the activation of the oncogenous agent would usually occur in the middle-aged hosts, the survival of the agent would have already been assured, the transmission of the agent to the host's offspring occurring prior to the outbreak of disease in the carrier-host. Leukemia, and other malignant tumors, would therefore be, according to this concept, egg-borne viral infections, like many other parasitic virus diseases of plants, insects, and birds.

Since in many, perhaps in most, instances, the oncogenous agents would never become activated during the life span of a single carrier-host, even though they would be transmitted from one generation to another, only now and then, separated by one or several generations of healthy persons would leukemia or another malignant tumor develop in some of the members of certain families of carriers. In humans, therefore, two successive cases of leukemia caused by the same, transmitted virus, could be separated by a century or two. The tracing of the epidemiological course of the leukemic virus in human beings would therefore represent, at this time at least, a task beyond means.

Direct experimental evidence, now available, suggests that not only in chickens but in mice also leukemia is caused by a filtrable, thermolabile agent, presumably a virus, transmitted from one generation to another directly through the embryos.[3] Although no experimental evidence is yet available concerning the nature of leukemia in cattle and human beings, the possibility should be considered that, as in chickens and mice, in other species also, including human beings, leukemia may be caused by transmissible agents. In cattle, numerous observations have been made of leukemia developing in several members of the same family in two or three successive generations. In human beings, one case has been reported in which three and perhaps four out of seven siblings, and another in which five out of eight siblings,[4] died from leukemia. Other observers have recorded leukemia developing in three successive generations in man. These instances are striking though rare. In most instances, the oncogenous agents would be so well adapted to human hosts as to cause no symptoms of disease in the great majority of carriers. This could explain why leukemia is a relatively rare disease, even though its agents might conceivably be carried by a large number of healthy hosts.

In the light of this concept, the development of leukemia or, for that matter, of other malignant tumors, in persons exposed to certain chemical poisons or physical stimuli, including radiation energy, could be regarded as a result of an activation, merely accidental, of a hitherto masked oncogenous agent, carried by such hosts since birth.

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A DOCTOR REPLIES

A member of the medical profession has pointed the way for other physicians when the profession is under unjustified attacks. Carlton E. Wertz of Buffalo, who is familiar to many for his active interest in medical affairs did not lose any time in replying to a critical editorial in the *Buffalo Evening News*. The editorial commented unfavorably and unfairly on the stand taken by the American Medical Association concerning the administration's controversial reinsurance bill. Dr. Wertz wrote a letter to the editor of the *Buffalo Evening News*, and it was

published in a prominent position in the paper. The editor is to be commended for his fairness in allowing so complete a reply, but Dr. Wertz deserves an extra garland for his alertness and his willingness to defend publicly what he believes is right. He used facts known to him and factual material available from the A. M. A. headquarters and as a result brought new light and understanding for many to a subject that has been confusing to and often misunderstood by laymen and doctors. This is the approach that should be taken by other doctors when their local newspapers or newscasters offer incomplete or slanted reports. The doctor in the community can be as effective as anyone if he will speak up to support that in which he believes or to criticize that which to him seems wrong. He need only be sure of his facts and then express himself with sincerity. All editors—and politicians also—realize the effectiveness of letter writers. It is time for more physicians to realize this for their own use and for the advancement of public welfare.

ENDOMYOCARDIAL FIBROELASTOSIS

Craig [1] in 1949 reported autopsy findings in 43 cases of a congenital heart disease characterized by thickening of the ventricular mural endocardium and a thick malformation of the valves in the majority of the cases. The hearts studied comprised the autopsy material at the Boston Children's Hospital from 1928 to 1948 and at the Boston Lying-In Hospital from 1932 until 1949. This type of heart abnormality in the past has been separated from the general group of congenital heart malformations because of the belief that they have their origin in an inflammatory process during the period of gestation. They have been considered as instances of "fetal endocarditis." Craig [1] stresses the fact that in these cases associated developmental anomalies both within the heart and in the remainder of the body were "conspicuously" absent. The subendocardial changes in the myocardium were quite specific for this type of cardiac malformation, none being found in the hearts with developmental failures. He did not favor the theory of a local inflammatory process in the substance of the valves or the endocardium but believed these lesions to be the result of abnormalities of development. He advanced the hypothesis that anoxemia is the cause of this entity.

Prior and Wyatt [2] added eight new cases to the group of endocardial fibroelastosis. This condition was oftenest seen at autopsy of infants dying within the first year of life. The lesion consisted of yellowish-white thickening of the endocardium that manifested a predilection for the left side of the heart. Most of the patients appeared normal at birth. The sudden onset of symptoms and the extremely short duration of life thereafter seemed to be characteristic of this disease. Cyanosis was the commonest presenting sign. There were also irritability, anorexia, and dyspnea. The hearts at autopsy showed enlargement, a thickened, gray, somewhat opaque endocardium, and thickening and fusion of the leaflets of the valves, the free margin of which presented a thickened, rolled border. The mural and the valvular lesions did not have the characteristics of an inflammatory process. These authors suggested the term endocardial dysplasia to replace fetal endocarditis and fibroelastosis. Collier and Rosahn [3] reported two cases in which there was microscopic evidence of hyperplasia of the fibrous and elastic tissues of the endocardium. Edmonds and Seelye [4] added six cases that were characterized by hypertrophy of the left side of the heart, thickening of the mural endocardium of the left ventricle, and distortion of the aortic and mitral valves. The case of Hill and Reilly [5] was unique in that all of the cardiac valves and the endocardium of all of the chambers were involved in the process. The histological picture suggested that this particular entity belongs in the group of collagen diseases.

Johnson [6] defined endocardial fibroelastosis as either diffused or focal thickening of the mural endocardium consisting predominantly of fibrous and elastic tissue. Among 210 congenitally malformed hearts he had found 23 exhibiting this condition. In his series of cases endocardial fibroelastosis developed in hearts having an associated malformation that could produce endocardial anoxia. These malformations usually involved an anomaly of the coronary arteries, a premature closure of the foramen ovale, or valvular atresias in which stagnation anoxia developed. He concluded that anoxia was the important factor in the development of congenital endocardial fibroelastosis.

Halliday,[7] in a recent report, analyzes 30 cases discovered during the five year period ending in 1952. In some of his cases autopsy revealed a rolled, nodular, valve margin, while in others there was a diffusely thickened and hyperplastic endocardium on microscopic examination. Abnormalities of the papillary muscles and associated valve structures appeared to be common to this type. Contrary to several series reported in the literature, which stress the absence of association of endomyocardial abnormalities with other congenital abnormalities either of the cardiovascular system or of other systems, his own series demonstrated the presence of associated abnormalities in 75%. In his group there were 36% with noncardiovascular anomalies and 57% with anomalies of cardiovascular nature. There was, however, no evidence of direct relationship between the endomyocardial fibroelastosis and any specific anomaly of any system. Coarctation of the aorta, hypoplasia of the aorta, and hypoplasia of a cardiac chamber were among the commoner associated anomalies. Halliday concluded that the condition is an idiopathic congenital anomaly frequently associated with hypoplasias and coarctation. The disease is primarily an anomaly of the subendocardium with secondary vascular and tertiary myocardial changes, related typically to compensatory myocardial hypertrophy and eventually dilatation.

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THE PRESIDENT'S PAGE

A MONTHLY MESSAGE

In an address before the House of Delegates of the American Medical Association in San Francisco, attention was called to the importance and urgency of providing adequately for the financing of the hospital care of the noninsurable groups in our population. In discussing the reinsurance proposal of the administration, it has been pointed out repeatedly that reinsurance would in no sense meet the needs of this group unless a federal subsidy was introduced. We have been assured that no subsidy is intended but remain skeptical of the government's power to keep the subsidy out once a mechanism is established by law for the entrance of the government into the insurance field. This concept has been one of our principal reasons for opposition to the reinsurance proposal.

Opposition to a program that we deem unwise and dangerous in no way solves the problem of providing for the health care of the uninsurable nor lessens our responsibility for working out a realistic and effective means of financing the necessary care for these persons. This is a problem of considerable magnitude and one that is steadily increasing as our population ages and as chronic and degenerative diseases more and more dominate the medical picture.

Various proposals have been put forward for participation of the federal government in financing the medical care of the low-income and the uninsurable segment of our population. Except in the categorical cases, such participation will be difficult to carry out without a degree of federal supervision and control that would be highly objectionable. Since we are dealing with a shifting and fluid part of the population, there could be no acceptable or realistic standard for federal aid. The medical needs of a person will vary with the duration and severity of his illness or disability and his immediate necessity and could not be measured by any national yardstick. If the federal government entered this field and contributed to the health care of this group, some type of national yardstick would become necessary. Political pressure would then be exerted to lengthen this yardstick until each year a larger segment of our population would claim government assistance in financing the cost of their medical care.

The composition of the uninsurable group, while fluid and to some extent undefinable, can be roughly described. It contains a large part of the 13,500,000 persons beyond the age of 65, a major portion of those with chronic diseases and long-term disabilities, a considerable number of the unemployed, and the over 5 million recipients of direct governmental assistance. It also contains a large group of persons whose incomes are so low that after paying for the daily necessities of life they have nothing left with which to purchase insurance or to pay for the cost of illness at the time it occurs. Numerically, these groups of uninsurables are variously estimated as comprising 30 to 35 million persons. The size of this group can be reduced to some extent by insurance coverage for those able to buy insurance but not able to meet the cost of illness at the time it occurs.

We believe the responsibility for financing the cost of illness in this group is a local and state concern. Only at the local level can the medical needs of individuals be determined. Only at the local level can their economic status be assessed in relation to their medical requirements at a particular time. Progress in establishing adequate state and local programs varies widely. In certain areas, it is reasonably adequate, but in others it is nonexistent or poor. A number of spot studies in this field have been made by our Council on Medical Service, and others are in progress. Patterns have been worked out in certain communities, and these experiences are available for the guidance of others.

It should be the responsibility of state and local societies to move actively in their areas to see that this need is met. It must be met from philanthropic, local, or state funds. The burden cannot be passed on to the hospitals without lowering their standards of service. The construction of more chronic disease and convalescent units in connection with conventional hospitals will decrease the financial burden by providing for the care of many of these persons at a lower per diem cost, but even this lowered cost must be met from some source. Further extension of insurance will subtract substantially from the total cost. The local societies should join with the hospitals in promoting sound voluntary prepayment insurance plans. The same joining of forces should take place at the state and local level. It should be the immediate and active concern of every local and state society to study the situation in their own areas and to formulate plans for meeting the medical needs of the low-income and noninsurable groups.

WALTER B. MARTIN, M.D., Norfolk, Va.

ORGANIZATION SECTION

BUILDING THE ANNUAL PROGRAM OF THE SECTIONS

Plans for the Annual Meeting of the American Medical Association usually begin a year in advance, at which time new officers of the various sections are elected or old officers retain their posts. By September the secretary of each section begins to think in terms of the program for the following June meeting, and subjects for consideration are accepted by him from the members of the American Medical Association as early as Labor Day. By mid-October the general outline of a section program is usually well advanced, and at that time the section secretary, and sometimes the section representatives to the Scientific Exhibit, meet in Chicago with the Council on Scientific Assembly and the Director of the Scientific Exhibit and his staff, to consider the program as a whole. Each secretary presents to the Council and to his brother secretaries an outline of his proposed program. At that time, joint meetings are usually arranged and panel discussions or symposiums are given consideration.

More active work on the program takes place between mid-October and mid-December, so that, soon after the first of the year, a secretary ordinarily has his program practically complete. The final arrangements are undertaken during the month of January and the first two weeks of February, the closing date usually being set for Feb. 15. To many members of the American Medical Association this date, four months in advance of the Annual Meeting, seems early, but it is necessary to adhere to it so that the preliminary program can be submitted for publication in THE JOURNAL about April 10.—Extract from an editorial in THE JOURNAL, March 20, 1954, page 1004.

MEDICAL ASSOCIATION OF GEORGIA

To permit readers of THE JOURNAL *to become better acquainted with the activities of state medical associations, articles describing them will appear from time to time in these pages.*—ED.

On March 20, 1849, in response to a call from the Medical College of the State of Georgia and the Georgia Medical Society of Savannah, which had been in existence since 1804, 76 physicians assembled in Macon to found the Medical Society of Georgia, known since 1873 as the Medical Association of Georgia. A previous attempt to organize a state medical association had been made in 1835. The suggestions made at that preliminary meeting, providing for the formation of county societies that should elect delegates to a state society, had met with favorable reception, and meetings were held in various cities. Although the foundation for a state society was thus carefully laid, the structure was not perfected until 1849. The new organization had as its objectives "the advancement of Medical knowledge—the elevation of professional character—the protection of the interests of its members—the extension of the bounds of Medical Science, and the promotion of all measures adapted to relieve suffering humanity and to protect the lives and improve the health of the community." As its first president the society chose Dr. Lewis Desaussure Ford, who for many years served as a member of the city council and as president of the board of health and in 1846 was elected mayor of Augusta. For almost 50 years Dr. Ford was professor of the principles and practice of medicine in the Medical College of Georgia, where he was dean for a long period. In an article written in honor of the centennial of the medical association, Dr. George A. Taylor of Augusta calls attention to a letter drafted by the faculty of the Medical College of Georgia in 1835 and sent to the other 15 medical colleges in the United States, which read, in part: "Thoroughly convinced that the profession, whose respectability it is alike our duty and inclination to advance, requires that the medical colleges of the United States, now, take some decided action upon this subject of Medical Education, we beg leave respectfully, to solicit your cooperation in effecting a Convention of Representatives from the medical colleges to be held in Washington, for the purpose of establishing an uniform system of requisitions for the degree of Doctor of Medicine; of regulating the courses of professional study; the extent of previous education; and counselling generally about the means of rendering our institutions most successful in diffusing the benefits of Medical Education." Dr. James J. Walsh in the "Encyclopedia Americana" attributes to this letter the formation of the American Medical Association.

The importance of the contributions of its physicians were manifested early in the history of the state of Georgia, which on Dec. 19, 1823, passed the first state birth registration law. It required the "clerks of the court of ordinary, in each county respectively to enter and register in a book" the dates of births of all persons on due proof made by affidavit or oath—a service for which the clerk was entitled to charge a 25 cent fee. In his "Notes on the History of the Medical Association of Georgia, 1920-1935," Dr. Allen H. Bunce of Atlanta, secretary-treasurer of the association during that period and later president, states: "In the spring of 1922, Georgia was finally admitted to the Registration Area. However, in June, 1925, the payment of local registrar's fees for the collection of birth and death records was declared unconstitutional by the Supreme Court. . . . The Medical Association of Georgia in 1927 helped to secure the passage of a constitutional amendment to make effective the law as to registering births. . . . Soon afterward Georgia was readmitted to the Registration Area. . . ." In 1930, despite its remarkable record of accomplishment and over the strenuous objections of the state medical association, the state board of health was abolished by the General Assembly. On reinstatement of the department several years later, the association sponsored a plan providing for a board of 14 members, 10 to be selected from a list submitted by the association, 2 to be dentists, and 2 pharmacists nominated by their respective organizations. The first board under the new law, said to be a model for the United States, was appointed to staggered terms, so that no subsequent governor could appoint a majority and so that there might be a continuity of policy.

The Academy of Medicine, Fulton County Medical Society, Atlanta, in which the Medical Association of Georgia maintains its headquarters.

In honor of the centennial of the association, the late Dr. Frank K. Boland, who had served as president of the state association, the Fulton County Medical Society, and the Crawford W. Long Memorial Association, compiled a history of the state organization. Among the great names of Georgia's early medical history is that of Dr. Long who, during the third annual meeting of the association, read his paper on the discovery of anesthesia that he had made 10 years previously. Through the joint efforts of the association and the Crawford W. Long Memorial Association, the statue of Dr. Long now stands in the Hall of Fame of the Capitol in Washington, D. C. Dr. Boland presided at the dedication in 1926.

The association has a membership of 2,273. Its officers include: Dr. Peter B. Wright, Augusta, president; Dr. H. Dawson Allen, Milledgeville, president-elect; Dr. Willard R. Golsan, Macon, and Dr. Milford B. Hatcher, Macon, first and second vice-president, respectively; and Dr. David H. Poer, Atlanta, secretary-treasurer. Mr. Milton D. Krueger is executive secretary.

MEDICAL NEWS

CALIFORNIA

Scholarship in Honor of Dr. Irish.—Dr. Cullen Ward Irish, Los Angeles, will be honored with a $10,000 scholarship to be given to his alma mater, Ohio State University School of Medicine, Columbus, by his son, Capt. Cullen Ward Irish II, Otis Air Force Base, Mass. The money is part of the first prize of $50,000 won by Captain Irish and his wife in a recent contest. The remainder of the prize money will go to CARE for Japanese orphanages, to the Veterans of Foreign Wars, and to the Air Force Aid Society. Dr. Irish is on the staffs of the Hospital of the Good Samaritan and Hollywood Presbyterian Hospital in Los Angeles and St. Joseph Hospital in Burbank.

Student Loan Fund.—A $30,000 student loan fund has been presented to the University of Southern California School of Medicine, Los Angeles, by the K. Arakelian Foundation of Fresno. The fund, available for the completion of medical education, will be made self-perpetuating through the repayment of loans. Applications for student aid will be handled by a special committee of the faculty representing each of the four classes in the school of medicine: Dr. Charles T. Sturgeon, clinical professor of surgery, chairman; Dr. Gordon K. Smith, assistant clinical professor of surgery; Dr. Ralph E. Homann Jr., assistant professor of medicine; Donald W. Visser, Ph.D., associate professor of biochemistry and nutrition; and Dr. Milton R. Hales, assistant professor of pathology.

CONNECTICUT

Dr. Clair Crampton Named Dean.—Dr. Clair B. Crampton, Middletown, has been appointed dean of freshmen of his alma mater, Wesleyan University, effective September, 1954. Dr. Crampton, who will have charge of the counseling of first-year students in academic and personal problems, will devote part time to his new Wesleyan duties, continuing his practice. Dr. Crampton has been director of student health at Wesleyan University since 1950 and in that capacity has been active in student counseling and in the deliberations of the college administration committee.

Personal.—Dr. William H. Weidman, consultant in tuberculosis at the Hartford Hospital, has been appointed assistant director of the division of tuberculosis and sanatoria of the Massachusetts State Department of Public Health. Dr. Weidman formerly served as superintendent and medical director of the State Tuberculosis Sanatorium of Norwich.——Ira V. Hiscock, M.P.H., professor of public health, Yale University School of Medicine, New Haven, has received the Shattuck award for outstanding contributions to the field of public health, established by the Massachusetts Public Health Association in 1950, and the 1954 medal of the Connecticut division of the American Cancer Society. Dr. Hiscock was recently elected president of the Association of Schools of Public Health of the United States and Canada.——Dr. William H. Upson, Suffield health director and past president of the Hartford County Medical Association, was named president-elect of the Connecticut Public Health Association at the annual meeting of the organization on May 13, in Meriden.

ILLINOIS

Physiologist to Head Shimer College.—F. Joseph Mullin, Ph.D., who has been dean of the faculty of Chicago Medical School and professor of physiology since 1951, has been elected president of 101-year-old Shimer College at Mount Carroll. He succeeds Aaron J. Brumbaugh, Ph.D., who relinquished the presidency to become director of a study of the educational needs of the state of Florida that is being made under the auspices of the Southern Regional Conference. Dr. Brumbaugh was dean of students of the University of Chicago before he became vice-president of the American Council on Education. Dr. Mullin served 13 years at the University of Chicago as associate professor of physiology, dean of students in the division of biological sciences, and secretary of the faculties of the university. He came to the University of Chicago in 1943 after teaching physiology three years at the University of Texas School of Medicine, Galveston. He is president of the National Intern Matching Program and has served on various committees of the Association of American Medical Colleges and the committee on postgraduate education of the Chicago Medical Society.

Physicians are invited to send to this department items of news of general interest, for example, those relating to society activities, new hospitals, education and public health. Programs should be received at least three weeks before the date of meeting.

Chicago

Leopold Kling Lecture.—Dr. Fred C. Roulet, professor of pathology at the University of Basel, Switzerland, will deliver the Leopold Kling lecture on reticuloses as neoplasia at the Mount Sinai Hospital, 2750 W. 15th Pl., Sept. 17, 11 a. m. At 4 p. m. he will discuss "Carcinoma of the Liver with Particular Reference to Its Relation to Cirrhosis." The medical profession is invited.

Society News.—At its annual meeting the Chicago Dermatological Society elected Dr. Julius E. Ginsberg, president; Dr. Edwin M. Smith, vice-president; and Dr. Irene A. Neuhauser, secretary-treasurer.——Newly elected officers of the Metropolitan Dermatological Society of Chicago include Dr. Franz Baumann, president; Dr. Harold W. Thatcher, vice-president; and Dr. Tibor Benedek, secretary-treasurer.——At the annual meeting the Chicago Urological Society elected Dr. John W. Ferrin, president; Dr. Joseph H. Kiefer, vice-president; and Dr. Don E. Murray, secretary-treasurer.

IOWA

Bierring Award in Bacteriology.—The first Bierring award in bacteriology at the State University of Iowa, Iowa City, established last spring in honor of Dr. Walter L. Bierring, director of the division of geriatrics, heart and chronic diseases of the Iowa State Department of Health, was recently presented to J. H. Gardner, a Des Moines student of the college of medicine. Dr. Bierring, a past president of the American Medical Association and professor emeritus of internal medicine at the university, made the presentation. Dr. Bierring taught the institution's first course in bacteriology 60 years ago. During the next year Mr. Gardner will hold a student fellowship in the department of pathology.

MASSACHUSETTS

Dr. Farnsworth to Direct Medical Care at Harvard.—Dr. Dana L. Farnsworth, Belmont, first full-time medical director at the Massachusetts Institute of Technology, Cambridge, and an associate physician at the Massachusetts General Hospital, Boston, has been selected as Henry K. Oliver professor of hygiene to direct all medical care in Harvard University, effective Sept. 1. Dr. Farnsworth, named assistant director of health at Williams College, Williamstown, in 1935, was made director of health in 1945 and a year later was appointed medical director at the Massachusetts Institute of Technology. During World War II, Dr. Farnsworth served as a commander with the medical corps of the U. S. Navy. He is a past president of the American College Health Association. He succeeds Dr. Arlie V. Bock, who retired this year after some 30 years of service at Harvard. Oliver professor of hygiene since 1935, Dr. Bock received the honorary degree of doctor of science at the Harvard University commencement exercises in June.

MISSISSIPPI

Fifty-Year Club.—Membership in the 50 Year Club was recently awarded by the Mississippi State Medical Association to Dr. Sherrod R. Towns of Union Church, Dr. Wade H. Sutherland of Booneville, Dr. George W. Googe of Rienzi, and Dr. George W. Land of Louin.

MISSOURI

Appoint Professor of Pathology.—Dr. W. Stanley Hartroft, professor of medical research, University of Toronto Faculty of Medicine, has been appointed Edward Mallinckrodt professor and head, department of pathology, Washington University School of Medicine, St. Louis, effective Sept. 1. Dr. Hartroft succeeds Dr. Robert A. Moore, who resigned as dean of the school of medicine and head of the department of pathology to become vice-chancellor in charge of the schools of the health professions at the University of Pittsburgh.

Personal.—At the annual picnic of the Three D's Club (Doctors, Dentists, and Druggists) at Nigro Brookside Farm, Overland Park, Kan., honor awards for long, outstanding community service in Kansas City were bestowed on Dr. John O. Skinner, Fred E. Byers, D.D.S., and Nick Hunter, Ph.G. Dr. Dominic M. Nigro is president of the group and Dr. Edwin C. White, one of its vice-presidents.——The University of Colorado conferred the degree of doctor of science on Dr. Wendell G. Scott, associate professor of clinical radiology, Washington University School of Medicine, St. Louis, at ceremonies in Boulder, June 5.

NEVADA

Nevada Hospitals Built with Hill-Burton Aid.—According to the section of hospital services of the Nevada State Department of Health, Nevada has 10 hospital construction projects, including a 72 bed addition now in the drawing stage. Beds have been built in each of the four categories: general, mental, chronic, and tuberculosis, and assistance has been given to the construction of such related facilities as dietary, laundry, laboratory, central supply, and radiological departments. The Lyon County Hospital, which will have 18 beds plus a 12 bed indigent wing, will replace an existing unacceptable facility. The total estimated cost of this project is $383,512, of which the federal share will be $227,738.66. The total number of beds added by the program, including the 72 bed addition on the drawing board, is 272, of which 160 are general, 60 mental, 36 tuberculosis, and 16 chronic. The projects show an aggregate cost of three million dollars, of which amount $1,800,000 will have come from the local level and $1,200,000 from the Hill-Burton program.

It is said that although the program has done a great deal to relieve an acute shortage of general hospital beds, much remains to be accomplished. The chief problem is one of adequate funds at the sponsor level. The Hill-Burton Act is also indirectly responsible for bringing the hospital licensing program into being in Nevada. The hospital program has received wide acceptance, and the present indications are that Nevada will continue to make full use of the funds alloted.

NEW HAMPSHIRE

Cancer Conference.—The Gordon Conference on Cancer will be held from Aug. 30 to Sept. 3 at Colby Junior College, New London, with Dr. Albert Tannenbaum, Chicago, as chairman and Dr. Jacob Furth, Oak Ridge, Tenn., vice-chairman. There will be a panel discussion of industry's questions on carcinogenic hazards on Monday, a symposium on cancer on Tuesday, and a symposium on mutagenesis and carcinogenesis on Wednesday. The sessions will end on Friday with the presentation of "Some Aspects of the Spread of Cancer in Man" by Dr. Otto Saphir, Chicago.

NEW JERSEY

State Medical Election.—Newly elected officers of the Medical Society of New Jersey include Dr. Elton W. Lance, Rahway, president; Dr. Vincent P. Butler, Jersey City, president-elect; Dr. Lewis C. Fritts, Somerville, and Dr. Albert B. Kump, Bridgeton, first and second vice-presidents, respectively; Dr. Marcus H. Greifinger, Newark, secretary; and Dr. Jesse McCall, Newton, treasurer.

Consultation Service for Convulsive Disorders.—The recently initiated New Jersey Consultation Service for Convulsive Disorders will accept referrals from physicians for patients with convulsive disorders who are financially unable to be referred to a private consultant. Physicians may secure referral forms from the headquarters of the service, 42 Walnut St., Newark 2 (Mitchell 3-7052), or by application to the contact physician in their areas. The service was created at the request of the Medical Society of New Jersey. Planned jointly through the medium of the advisory council to the epilepsy project of the New Jersey Society for Crippled Children, it represents a careful dovetailing of separately financed seizure programs of the New Jersey Society for Crippled Children and Adults, the state department of institutions and agencies, and the state department of health. Dr. Melvin D. Yahr, medical consultant for the statewide clinic program, will travel to all parts of New Jersey for consultation clinics. A report will be sent to the referring physician, in whose hands treatment will remain. The following contact physicians have been approved by the Medical Society of New Jersey to act in a liaison capacity between the consultant and the referring physicians: Dr. William L. Sprout of Salem County Memorial Hospital, Salem; Dr. Arthur H. Randelman of St. Francis Hospital, Trenton; Dr. Catherine E. Spears, Morristown Memorial Hospital, Morristown; and Dr. Richard E. Gordon, Englewood Hospital, Englewood. The consultation service sessions will be held in each of the four areas of the state one day each month, rotating each week from one area to another.

NEW YORK

Lecture on Ureteral Injuries.—Dr. Richard W. TeLinde, professor of gynecology, Johns Hopkins University School of Medicine, Baltimore, will present "Ureteral Injuries, Genital Fistulae and Stress Incontinence," Sept. 16, 8:30 p. m., at the Jewish Sanitarium and Hospital for Chronic Diseases, 86 E. 49th St., Brooklyn.

New Medical-Dental Building at Buffalo.—Samuel P. Capen Hall, which was recently completed, provides expanded facilities for the medical and dental schools of the University of Buffalo, a private, independent institution. Funds for construction of the

Samuel P. Capen Hall.

hall were contributed by private persons and corporations. Expansion of enrollment is anticipated in the medical school, which has equipment for 80 students in each year of the four year programs, and in the dental school, which is equipped for 60. Dr. Samuel P. Capen, for whom the new building is named, served as chancellor of the university from 1922 to 1950 and is now chancellor emeritus.

New York City

First Harvey Lecture.—Vincent du Vigneaud, Ph.D., professor of biochemistry, Cornell University Medical College, will deliver the first Harvey lecture of the 1954-1955 (50th anniversary) series at the New York Academy of Medicine, Sept. 23. Dr. du Vigneaud will present "Hormones of the Posterior Pituitary Gland: Oxytocin and Vasopressin."

University News.—Dr. Severo Ochoa, professor and chairman, department of pharmacology, has been appointed professor and chairman of the department of biochemistry of New York University-Bellevue Medical Center's college of medicine. Before his affiliation with New York University's college of medicine in 1942, Dr. Ochoa held faculty appointments with the University of Madrid Medical School in Spain; Kaiser-Wilhelm Institute for Medical Research, Heidelberg, Germany; University of Oxford School of Medicine, Oxford, England; and Washington University School of Medicine, St. Louis. Dr. Bernard D. Davis, who joined the medical center's faculty on July 1, now directs the department of pharmacology. He was previously in charge

of the U. S. Public Health Service tuberculosis research laboratory in the department of public health at Cornell University Medical College.

Conference on Cancer of the Digestive Tract.—A round-table conference on the diagnosis and management of cancer of the digestive tract will be held under the auspices of the Irwin Strasburger Memorial Medical Foundation, Nov. 12, from 9:30 a. m. to 1 p. m., in the auditorium of Memorial Center for Cancer and Allied Diseases, 444 E. 68th St. Participating in the discussion will be Drs. Thomas P. Almy, Alexander Brunschwig, Michael R. Deddish, John A. Evans, Gordon P. McNeer, George T. Pack, Milton R. Porter, Robert S. Sherman, William L. Watson, and Frederick S. Philips, Ph.D., New York; Sara M. Jordan, Samuel F. Marshall, and Richard H. Sweet, Boston; and Isidor S. Ravdin and W. Emory Burnett, Philadelphia. Reservations should be made before Nov. 5 through the Office of the Assistant Clinical Director, Memorial Center, 444 E. 68th St., New York 21; telephone TRafalgar 9-3000, ext. 593.

OHIO

Society News.—At the meeting of the Cleveland Society of Electroencephalographers Dr. Edward M. Zucker, Cleveland, was elected president; Dr. Laurence M. Weinberger, Akron, vice-president; and Dr. Victor M. Victoroff, Cleveland, secretary-treasurer.

Personal.—Dr. Hugh J. Means has retired as professor and chairman of the department of radiology, Ohio State University College of Medicine, Columbus.——Dr. Ernest Bueding, who has been affiliated with Western Reserve University School of Medicine, Cleveland, since 1944 and has served as associate professor of pharmacology since 1947, has been appointed professor and head of the department of pharmacology at the Louisiana State University School of Medicine, New Orleans. Dr. Bueding, who has written about 75 papers dealing principally with carbohydrate metabolism, will continue his research under a $28,000 public health service grant while at the Louisiana school of medicine.——Dr. Robert M. Stecher, president, Cleveland Health Museum, will present the Heberden oration, entitled "Heberden's Nodes," at the Post-Graduate Medical School of London, Sept. 24.——Dr. Bruno Gebhard, director, Cleveland Health Museum, will read a paper, "From Medicine Show to Health Museum," at the 14th International Congress of the History of Medicine in Rome, Italy, Sept. 14.——On Alumni Day, May 28, the Alumni Association of Harvard Medical School in Boston awarded the Alumni Association prize, a check for $200, to Dr. Oscar Stanton DePriest III of Urbana, a graduate of the class of 1954.

Hematology Symposium.—Through the support of the National Vitamin Foundation, a symposium on the nutritional aspects of blood formation will be held at the University of Cincinnati College of Medicine, Oct. 22, from 9:15 a. m. to 5 p. m. The morning session will be under the chairmanship of Dr. Richard W. Vilter, associate professor of medicine, and the afternoon session under that of Dr. Marion A. Blankenhorn, director of the department of internal medicine, Cincinnati General Hospital. The symposium is open to all interested physicians and scientists. The following program will be presented:

Iron Metabolism in Relation to Microcytic Hypochromic Anemia, Carl V. Moore, St. Louis.

Relationship of Copper, Cobalt, and Trace Elements to Hematopoiesis, George E. Cartwright, Salt Lake City.

Some Metabolic Interrelationships of Folic Acid, Vitamin B_{12} and Ascorbic Acid, Jesse N. Williams, Ph.D., Madison, Wis.

Interrelationship of Folic Acid, Vitamin B_{12} and Ascorbic Acid in Patients with Megaloblastic Anemia, John F. Mueller and John J. Will, Cincinnati.

Absorption and Utilization of Vitamin B_{12}, Robert F. Schilling, Madison, Wis.

Relationships of Hormones to Utilization of Essential Nutrients in Erythropoiesis, Roger C. Crafts, Ph.D., Cincinnati.

Antimetabolites and Antibiotics as Tools for Research on Blood Formation, Thomas H. Jukes, Ph.D., Pearl River, N. Y.

Stercobilin and Hematopoiesis, G. Watson James III, Richmond, Va.

Essential Nutrients in the Management of Hematopoietic Disorders of Human Beings—A Resume, Richard W. Vilter, Cincinnati.

PENNSYLVANIA

Dr. Cummins Goes to Tennessee.—Dr. Alvin J. Cummins, associate in medicine at the Hospital of the University of Pennsylvania, Philadelphia, will join the staff of the University of Tennessee College of Medicine in Memphis as an assistant professor of medicine. He will combine research and teaching, further develop the gastroenterology clinic and hospital activities at John Gaston Hospital and the University of Tennessee, and develop a postgraduate training program for research fellows and residents at the hospital.

Personal.—A testimonial dinner honored Dr. Michael Margolies, Coatesville, who for 25 years was president of the Chester County Tuberculosis and Health Society. Dr. George E. Dietrich, Coatesville, served as toastmaster. The guest speaker, John H. Biddle, past president of the Pennsylvania Tuberculosis and Health Society, spoke on the subject "Tuberculosis Is a World Problem."——Dr. Leroy E. Chapman, Warren, was awarded an honorary degree of doctor of laws at the June commencement of Jefferson Medical College of Philadelphia.

Society News.—At the annual meeting of the Eastern Pennsylvania chapter of the Arthritis and Rheumatism Foundation, Dr. John Lansbury, Philadelphia, was elected president, succeeding Dr. Joseph L. Hollander, Philadelphia; Dr. Philip R. Trommer, Philadelphia, was chosen vice-president.——The Pennsylvania Academy of Physical Medicine and Rehabilitation recently elected the following officers: Dr. Albert A. Martucci, Philadelphia, president; Dr. Francis J. Bonner, Ardmore, vice-president; and Dr. J. Murl Johnston, Pittsburgh, secretary-treasurer.——Officers of the Wainwright Tumor Clinic Association of Pennsylvania for 1954 include: Dr. S. Gordon Castigliano, Philadelphia, president; Dr. James Bloom, Harrisburg, vice-president; Dr. David W. Hughes, Philadelphia, secretary; Dr. Russell B. Roth, Erie, treasurer; Dr. Harvey F. Smith, Harrisburg, counsellor; and Mr. George T. Furlong, Harrisburg, executive secretary. The 1955 annual meeting will be held in Philadelphia.

Philadelphia

Prize for Pediatric Essay.—The Philadelphia Pediatric Society offers a prize of $100 for the best paper submitted by an intern or pediatric resident at any hospital in the Philadelphia area on any subject related to pediatrics, of either a clinical or a research nature. Papers should be submitted to Dr. Fred H. Harvie, Secretary, 133 S. 36th St., Philadelphia 4, by April 1, 1955.

Pediatric Allergy Clinic.—A new children's allergy clinic for the treatment of hay fever, rose fever, sensitivity to foods, and other allergies has been established in the first floor clinic area of the children's department, Philadelphia General Hospital, 34th St. and Curie Ave. The clinic will be held each Friday at 1 p. m. Activities in the clinic will include testing for allergies, inoculations, and other therapies.

University News.—Dr. Herbert R. Hawthorne, professor of surgery and chief of the surgical service at Graduate Hospital of the University of Pennsylvania and at the American Hospital for Diseases of the Stomach, has been elevated to the chairmanship of the department of surgery in the graduate school, University of Pennsylvania School of Medicine. Dr. Joseph P. Atkins, clinical professor of bronchology, esophagology, and laryngeal surgery and a member of the staffs of five hospitals in the Philadelphia and Camden area, has been appointed chairman of the department of bronchology, esophagology, and laryngeal surgery in the graduate school. They succeed Dr. William Bates and Dr. Gabriel Tucker, respectively, who will remain active in teaching programs at the graduate school of medicine and in clinical activities at Graduate Hospital.

Pittsburgh

Hospital News.—Ground has been broken at Allegheny General Hospital for a new wing to house Pittsburgh's first cobalt beam therapy unit and additional facilities of the hospital's department of radiology. The unit will be enclosed in a specially designed, 21 in. thick concrete center. The services of the tumor clinic on

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the first floor of the new building will be available to all patients in or out of the hospital who are referred by their physicians. Recommendations for treatment of these patients will be made to the physician referring the patient to the clinic.

Drs. Harbison and Salk to Head Departments.—Initial steps toward integration of the teaching programs in the schools of medicine, nursing, dentistry, and pharmacy at the University of Pittsburgh Health Center (THE JOURNAL, Jan. 30, 1954, page 428) have been taken with the appointment of Dr. Samuel P. Harbison as head of surgery and Dr. Jonas E. Salk as head of preventive medicine. Dr. Harbison will assume his duties in September. Dr. Salk is not expected to undertake his new activities until completion of the poliomyelitis vaccine tests in which he is now engaged and which will probably require the greater part of his time during the next two years. Dr. Harbison was in military service from 1942 to 1946, when he became professor of surgery at the University of Pittsburgh School of Medicine and, subsequently, chairman of that department. He also is senior surgeon at Presbyterian and Woman's hospitals, associate surgeon at Allegheny General Hospital, and consultant surgeon at the Veterans Administration Hospital and the Sewickley Valley Hospital. Dr. Salk has been affiliated with the University of Pittsburgh since 1947. During World War II he was a consultant to the Secretary of War in epidemic diseases and a member of the commission on influenza, Army Epidemiological Board. In 1947 he was made consultant in epidemic diseases to the Secretary of the Army, and he held this appointment as well as his membership on the commission on influenza until recently, when the studies on poliomyelitis occupied his full time. Dr. Salk is on the consulting staff of the Municipal Hospital for contagious diseases and the Presbyterian Hospital, Pittsburgh.

TENNESSEE

Danciger Memorial.—As a memorial to the late Dr. Jacob A. Danciger, assistant professor of pediatrics at the University of Tennessee College of Medicine, Memphis, specialized equipment that will benefit newborn babies and small children will be purchased. According to Dr. F. Thomas Mitchell, chief, division of pediatrics, and chairman of the memorial fund committee, the major portion of the fund will be spent for apparatus with which blood chemistry determinations may be made by micro methods.

University News.—Dr. I. Frank Tullis, Memphis, has been appointed to succeed the late Dr. Conley Hall Sanford as professor of medicine and chief of the division of medicine at the University of Tennessee College of Medicine, Memphis.——Dr. Thomas D. Moore, Memphis, is retiring as head of the department of urology at the University of Tennessee College of Medicine but will continue as professor of urology. Dr. Moore, a charter diplomate of the American Board of Urology, has represented the A. M. A. Section on Urology on the board since 1949. He is now serving as president of the American Urological Research Foundation.——Dr. Nicholas Gotten, associate professor of neurology and psychiatry at the University of Tennessee College of Medicine, Memphis, and in charge of the neurology section, has been made professor. Dr. Richard N. Winger and Harry H. Wilcox, Ph.D., have been advanced from assistant professors of anatomy to associate professors; Daniel J. Cavanaugh, Ph.D., and Calvin Hanna, Ph.D., from instructors of pharmacology to assistant professors; and Lester Van Middlesworth, Ph.D., from assistant professor of physiology to associate professor.

TEXAS

Industrial Health Conference.—The Houston Chamber of Commerce will sponsor its seventh industrial health conference Sept. 23 to 25 at the Shamrock Hotel. At 10:30 a. m. Thursday Dr. Sidney Schnur, Houston, chairman, will speak. Gordon Gray, president, University of North Carolina and former secretary of the Army, will give the luncheon address Thursday. The afternoon session will be devoted to the following symposium, entitled "Industry in the Atomic Age":

Radioisotopes in Industry, George Manov, Ph.D., Washington, D. C.
Plant and Personnel Protection, William D. Norwood, Richland, Wash.
Biological Effects of Atomic Blasts, John C. Bugher, Washington, D. C.
Industry's Role in Civil Defense, Mr. Val Peterson, Washington, D. C.

Friday morning the following symposium, "Absenteeism, Alcoholism, and Mental Health in Industry," will be presented at 9:45 a. m.

Absenteeism, Norman Plummer, New York.
Alcoholism in Industry, George H. Gehrmann, Wilmington, Del.
Importance of Mental Health for Employees, Robert L. Sutherland, Ph.D., Austin, Texas.
Emotional Problems of Executives, William C. Menninger, Topeka, Kan.

Dr. Elmer Hess, Erie, Pa., President-Elect, American Medical Association, the luncheon speaker on Friday, will discuss "Industry and Medicine." "Establishing Effective Health Programs in Industry" will be the subject of the symposium Friday afternoon, when the following presentations will be made:

Philosophy of Industrial Health Programs, Kieffer D. Davis, Bartlesville, Okla.
A Program for Large Industry, James H. Sterner, Rochester, N. Y.
A Program for Small Industry, Mr. Maston Nixon, Corpus Christi, Texas.
Air Force Industrial Health Program, Lieut. Col. John Boysen, Dayton, Ohio.

"Medicolegal Aspects of Industrial Nursing" will be discussed Saturday, 10 a. m., by Mr. R. W. Gilbert, Freeport, after which Jane Weaver, R.N., Dallas, will outline the responsibility for accurate records and Dr. John L. Otto, Galveston, will describe "The Approach to Problems of Mental Hygiene." Speaker at the luncheon session will be Dr. Kieffer D. Davis, Bartlesville, Okla., president-elect, Industrial Medical Association, whose topic will be "Nurses' Duties in a Health Maintenance Program." At 2 p. m. there will be a tour of the Texas Medical Center.

WEST VIRGINIA

Camp Galahad Charter.—A charter has been issued by the secretary of state for the new state camp for medically handicapped children, Camp Galahad, Inc. (THE JOURNAL, May 15, page 292), located on Blue Creek in Clay County, about 40 miles north of Charleston. The new camp site includes 10 acres, on which six cabins, each built to house 16 children, will be constructed, together with a mess hall, kitchen, dispensary, and cabin for the director. An artificial lake about 75 ft. wide and from 800 to 1,000 ft. long has already been constructed. The camp will be available during separate periods in the summer to diabetic, crippled, cardiac crippled, and deaf and blind children.

WISCONSIN

Baseball's Gift to Medical School.—Marquette University School of Medicine, Milwaukee, has received a gift of "about $25,000" from the Milwaukee Braves Baseball Club. The money will be used to purchase an electron microscope for basic research in cell structure and growth.

Personal.—Dr. Harvey L. Daiell, scientific director of Lakeside Laboratories, Inc., Milwaukee, has left for Europe to visit England, France, Germany, Switzerland, Spain, Italy, and the Scandinavian countries. Dr. Daiell plans to participate in the World Medical Association's annual meeting in Rome, Sept. 26 through Oct. 2, and will attend the International Congress on Diseases of the Chest, Oct. 4 to 8, in Barcelona, Spain.

Dr. Davis Retires as Department Chairman.—Dr. Frederick Allison Davis has retired as chairman of the University of Wisconsin's department of ophthalmology, which he founded 30 years ago. First professor of ophthalmology and, for a time, of otolaryngology at the University of Wisconsin Medical School, Madison, Dr. Davis gained recognition for his studies in hereditary diseases of the eye and his many publications on ophthalmic surgery, especially the perfection of techniques and methods of operations for the removal of cataracts. His investigations first demonstrated that glioma of the optic nerve and chiasm was but a part of a more widespread hereditary anomaly known as Recklinghausen's disease. For his work in this field Dr. Davis was awarded the Hermann Knapp gold medal by the A. M. A. Section on Ophthalmology, which he served as vice-chairman in 1953. Dr. Peter A. Duehr, who has worked with Dr. Davis for 20 years and is affiliated with him in the Davis and Duehr Clinic, will succeed him as chairman of the department of ophthalmology, of which he is associate professor.

ALASKA

Ten Million Dollar Medical Center at Anchorage.—The new Alaska Native Service medical center, recently opened at Anchorage, includes a five story, X-shaped hospital building with a sixth story solarium on one wing and a double tiered, H-shaped quarters building across a circular plaza. The hospital, the largest single A. N. S. hospital in Alaska, contains 400 beds, at least 300 of which are expected to be used by patients with tuberculosis. About 12, reserved for mental patients, are said to provide the first treatment facilities for mental patients established in Alaska. Since the hospital is supported by the Bureau

Alaska Native Service Hospital, Anchorage

of Indian Affairs, its facilities are open only to Indians, Eskimos, and Aleuts. Dr. Theodore E. Hynson, Juneau, area medical officer, is in charge of the medical program of the Alaska Native Service. Dr. Hynson, who came to Alaska in 1951 from West Virginia, has been in public health work since 1937. He formerly served in Delaware, Kentucky, and Virginia.

GENERAL

Awards to Proctologists.—The American Proctologic Society presented the following awards at the annual meeting in Los Angeles, June 2 to 5: The Hermance plaque to Dr. Edward D. Parkinson, Boise, Idaho, for his paper, "Hemorrhoids—An Operative Technic for Effecting a Permanent Cure"; the A. B. Graham award to Dr. Lloyd F. Sherman, Minneapolis, for his paper, "A Reevaluation of the Factitial Proctitis Problem"; the Ohio Valley Proctologic Society award to Dr. Patrick H. Hanley, New Orleans, for his paper, "Preservation of the Anal Sphincter in Correcting Imperforate Anus with Low Rectovaginal and Rectoperineal Fistula"; and the Collier Ford Martin award to Dr. Willard H. Bernhoft, Buffalo, for his exhibit, "Routine Sigmoidoscopy on 100% of All Operative Cases."

Life Insurance Medical Research Fund.—Applications for awards available July 1, 1955, will be received by the Life Insurance Medical Research Fund as follows: (1) postdoctoral research fellowships, until Oct. 29, preference being given to applicants who wish to work on cardiovascular function and disease or related fundamental problems; minimum stipend $3,500, with allowances for dependents and necessary travel; (2) grants to institutions in aid of research on cardiovascular problems, until Nov. 15. Support is available for physiological, biochemical, and other basic work broadly related to cardiovascular problems as well as for clinical research in this field. Information and application forms may be obtained from the Scientific Director, Life Insurance Medical Research Fund, 345 E. 46th St., New York 17.

Catastrophic Accidents.—According to the Metropolitan Life Insurance Company, catastrophic accidents—those killing five persons or more—took less than half as many lives in the United States during the first six months of this year as in the comparable period of 1953, and fewer than in most of the like periods of the last 15 years. This year's half-year total was slightly over 500 deaths. In general, the trend was toward (1) decreases in catastrophic deaths from tornadoes and civilian aviation, railroad, and water transportation accidents and (2) a slight increase in similar deaths in military aviation and in dwelling and apartment fires. During the first half of 1953, deaths from major tornadoes mounted to more than 400; this year there were less than 10. The largest single catastrophe this year was the flood in southwest Texas, which cost 23 lives.

Prevalence of Poliomyelitis.—According to the National Office of Vital Statistics, the following number of reported cases of poliomyelitis occurred in the United States and its territories and possessions in the weeks ended as indicated:

Area	July 31, 1954: Paralytic Type	July 31, 1954: Total Cases Reported	Aug. 1, 1953 Total
New England States			
Maine	..	..	14
New Hampshire	..	1	15
Vermont	1	1	1
Massachusetts	4	9	21
Rhode Island	..	2	5
Connecticut	2	8	7
Middle Atlantic States			
New York	18	56	134
New Jersey	9	19	29
Pennsylvania	..	30	39
East North Central States			
Ohio	11	60	124
Indiana	11	30	33
Illinois	37	78	90
Michigan	20	78	96
Wisconsin	3	17	21
West North Central States			
Minnesota	10	36	104
Iowa	21	80	25
Missouri	6	19	49
North Dakota	..	7	10
South Dakota	..	3	15
Nebraska	8	23	21
Kansas	11	42	33
South Atlantic States			
Delaware	3	4	..
Maryland	1	3	33
District of Columbia	3	4	4
Virginia	17	28	42
West Virginia	3	8	38
North Carolina	16	55	87
South Carolina	8	23	12
Georgia	8	36	13
Florida	6	48	39
East South Central States			
Kentucky	28	50	18
Tennessee	1	31	53
Alabama	10	39	21
Mississippi	10	43	13
West South Central States			
Arkansas	13	21	12
Louisiana	16	34	25
Oklahoma	9	40	18
Texas	63	163	92
Mountain States			
Montana	..	2	9
Idaho	..	3	3
Wyoming	1	4	2
Colorado	6	12	10
New Mexico	No report		5
Arizona	3	9	24
Utah	..	4	12
Nevada	..	5	1
Pacific States			
Washington	3	11	10
Oregon	4	10	7
California	113	222	147
Territories and Possessions			
Alaska	6	15	1
Hawaii	..	3	3
Puerto Rico	..	..	..
Total	529	1,510	1,630

The Public Health Service reports that, during the first seven months of 1954, poliomyelitis cases (9,185) were 7% behind the total (9,840) during the same period last year. Both years are far below the record of 10,582 cases reported in the first seven months of 1952. More than a third of the 1954 cases were in three states: California, 1,525; Texas, 1,400; and Florida, 619.

Fire Ordinance for Nursing Homes.—The National Board of Fire Underwriters has announced publication of a new edition of its "Suggested Ordinance on Nursing, Convalescent and Old Age Homes," first issued in 1945. Within the last 10 years four of the more tragic fires in nursing and old age homes took the lives of 88 persons. According to the board, the most important causes for the loss of life in those and many other fires in similar homes were the use of highly combustible fibreboard on interior walls and ceilings, unenclosed stairs and dumbwaiters, lack of sufficient exits, inadequate fire separation for parts of buildings

containing special fire hazards, and lack of automatic sprinkler protection. Persons wishing to obtain a copy of "Suggested Ordinance on Nursing, Convalescent and Old Age Homes" should write to the Engineering Department, National Board of Fire Underwriters, 85 John St., New York 38.

Hospital and Medical Center Affiliate.—St. Vincent Hospital, Worcester, Mass., has entered into an affiliation with the Georgetown University Medical Center and has appointed Dr. John F. Stapleton, instructor in medicine of the Georgetown University School of Medicine, Washington, D. C., as full-time director of medical education. Dr. Harold J. Jeghers, director of the department of medicine at the center, has been appointed consultant in medical education on the St. Vincent staff. Dr. Francis M. Forster, dean of the medical school, is serving as consultant in neuropsychiatry. Other department heads at the university are serving in comparable consultant capacities. The affiliation is similar to that between Georgetown and the Mercy Hospital of Buffalo as well as St. Mary's Hospital of Rochester, N. Y. The program is designed to improve the graduate and postgraduate level of medical education in the participating hospital.

Otorhinologic Society for Plastic Surgery.—The American Otorhinologic Society for Plastic Surgery, Inc., will meet at the Waldorf-Astoria Hotel, New York, at 5 p. m., Sept. 19, under the presidency of Dr. Matthew S. Ersner, Philadelphia, who will serve as moderator for the round-table discussion on plastic surgery of the head and neck, to be presented at dinner, 7:45 p. m., preceding the last two papers on the following program:

(1) Demonstration of Repair of Fractures Around the Orbit and (2) Immediate Repair of Fractures Around the Orbit, William A. McNichols Sr., Dixon, Ill.
Role of the Nasal Fascia in Rhinoplasty, Joseph G. Gilbert, Roslyn Heights, N. Y.
Principles and Mechanics of Surgery of the Nasal Bones: Practical Demonstration on Dry Specimens, Harry Neivert, New York.
Implants: Their Use in Plastic and Reconstructive Surgery of Head and Neck, John J. Conley, New York.
Skin Grafting Simplified: Utilizing a Mechanical Skin Grinder and Sprayer, John Jenney, New York.

Cancer Society Clinical Fellowships.—The American Cancer Society's program of clinical fellowships, begun in 1948, will continue through the next institutional year, July 1, 1955, to June 30, 1956. The clinical traineeship program for those with one year's postgraduate training has been abolished. Fellowships will be made available primarily to teaching institutions approved by the A. M. A. Council on Medical Education and Hospitals. Applications should be addressed to Dr. Brewster S. Miller, American Cancer Society, 47 Beaver St., New York 4, via the executive officer of the institution, before Sept. 15. Letters of application should include: (1) number of fellowships applied for; (2) funds available to the institution from other sources for partial support of fellows; (3) specialty contemplated for the fellow's training; (4) name of person under whose supervision the fellow will be trained; (5) date the fellowship will commence; and (6) a thorough documentation as to the training the fellow will receive at the institution. Applicants must be (1) not over 40 years of age on the next birthday following commencement of fellowship tenure and (2) citizens of the United States. The stipend will be $3,600 per year.

Tumor Material Requested for Registry.—The American Association for the Study of Neoplastic Diseases invites cooperation in the establishment of a tumor registry, owned and directed by the association. This registry will be a gradually increasing registry of tumors contributed by members of the association or by others interested. Each member is requested to send to the association tumor material for inclusion in the registry. There may be available about 20 specimens for each member attending the 1955 annual meeting in Baltimore to be studied and to become the property of the members attending. The remainder of the specimens will be continued in the registry. The following procedure should be followed in submitting tumor material: 1. Send the specimen fixed in 10% formalin or in appropriate paraffin block. 2. If possible, send material enough for 500 slides per tumor. 3. Blocks of tissue should be representative of the tumor in question. 4. A clinical abstract of about 50 words should accompany the specimen. 5. Mail the material to: Tumor Registry, American Association for the Study of Neoplastic Diseases, % Dr. John A. Wagner, Lutheran Hospital, Baltimore. Every member of the association and anyone interested in the study of neoplastic diseases is urged to contribute any case of interest or teaching value as soon as possible and as frequently as possible.

Television Symposium on Hypertension.—On Sept. 23, 6 to 7 p. m., Eastern Daylight Saving Time, the American College of Physicians will utilize television through a national closed circuit over the Columbia Broadcasting System for a symposium on the management of hypertension. This telecast is made possible through the cooperation and support of Wyeth Laboratories, Inc., of Philadelphia. The physicians who will participate include: Cyrus C. Sturgis, president, American College of Physicians, and professor of internal medicine, University of Michigan Medical School, Ann Arbor; F. H. Smirk, professor of medicine, University of Otago Faculty of Medicine, Dunedin, New Zealand; Robert W. Wilkins, chief, hypertension clinic, Massachusetts Memorial Hospitals, Boston; Garfield G. Duncan, director, medical division, Pennsylvania Hospital, Philadelphia; and Edward D. Freis, adjunct clinical professor of medicine, Georgetown University School of Medicine, Washington, D. C. Dr. Smirk appears on the program as an official representative of the Royal Australasian College of Physicians in connection with an exchange-guest program being arranged between the two colleges. The 23 receiving stations to be used for the closed-circuit telecast are located in Boston; New York; Philadelphia; Washington, D. C.; Pittsburgh; Charlotte, N. C.; Atlanta, Ga.; Cincinnati; Detroit; Chicago; St. Louis; Milwaukee; Minneapolis; Memphis, Tenn.; Dallas and Houston, Texas; New Orleans; Denver; Salt Lake City; Los Angeles; San Francisco; Baltimore; and Cleveland.

FOREIGN

Congress for Cell Biology.—The International Congress for Cell Biology will be held at Leiden, the Netherlands, Sept. 1 to 8. Among the topics for discussion are induced enzyme synthesis, immunobiological concepts of cellular growth and differentiation, virus synthesis, and thyroid secretion (activation and inhibition).

International Congress of Hydatidosis.—The Fifth International Congress of Hydatidosis will be held in Madrid, Spain, Sept. 24 to Oct. 2. On the opening day there will be a round-table discussion of statistics, and reports from various countries will be given by the national delegates. On Saturday the theme of the biological section will be "Normalization of the Biological Reactions Used in the Diagnosis of Hydatidosis." Cardiac hydatidosis will be discussed during the meeting of the medical-surgical section Monday. On Tuesday, during a discussion of epidemiology and economic and social aspects of hydatidosis, Dr. Thomas B. Magath, Rochester, Minn., will present "The Rustic Nature of the Echinococcus in the U. S. A." A symposium on pulmonary hydatidosis will be held Thursday in joint session with the 13th conference of the International Union Against Tuberculosis.

DEATHS IN OTHER COUNTRIES

Dr. Evert Gorter, professor emeritus of pediatrics in the University of Leiden in the Netherlands, died of neoplastic disease in February at the age of 71. Dr. Gorter was an honorary member of the American Pediatric Society and served as editor of the Dutch pediatric journal *Maandschrift voor kindergeneeskunde* and of *Acta paediatrica*. In the early 1940's he was invited to take over the chair of pediatrics at Ghent, Belgium, and to reorganize the pediatric clinic there. For some years he commuted three days a week to Ghent. A victim of chronic arthritis, Dr. Gorter spent his last 15 years in a wheel chair, from which he continued to carry on all his activities. With the invasion of Holland in World War II, he was removed from his post at the university and sent to a small town in the north of Holland to practice pediatrics. At the close of the war he returned to his post at Leiden, where he remained until his retirement a year ago.

MEETINGS

AMERICAN MEDICAL ASSOCIATION: Dr. George F. Lull, 535 North Dearborn St., Chicago 10, Secretary.
1954 Clinical Meeting, Miami, Florida, Nov. 29-Dec. 2.
1955 Annual Meeting, Atlantic City, N. J., June 6-10.
1955 Clinical Meeting, Boston, Nov. 29-Dec. 2.
1956 Annual Meeting, Chicago, June 11-15.
1956 Clinical Meeting, Seattle, Nov. 27-30.

AMERICAN MEDICAL ASSOCIATION PUBLIC RELATIONS INSTITUTE, Drake Hotel, Chicago, Sept. 1-2. Mr. Leo E. Brown, 535 N. Dearborn St., Chicago 10, Director.

ACADEMY OF PSYCHOSOMATIC MEDICINE, New York, Oct. 8-9. Dr. Ethan Allan Brown, 75 Bay State Road, Boston 15, Secretary.

AMERICAN ACADEMY OF OPHTHALMOLOGY AND OTOLARYNGOLOGY, The Waldorf-Astoria, New York, Sept. 19-24. Dr. W. L. Benedict, 100 First Avenue Bldg., Rochester, Minn., Executive Secretary.

AMERICAN ACADEMY OF PEDIATRICS, Palmer House, Chicago, Oct. 4-7. Dr. E. H. Christopherson, 610 Church St., Evanston, Ill., Secretary.

AMERICAN ASSOCIATION OF BLOOD BANKS, The Shoreham, Washington, D. C., Sept. 13-16. Miss Marjorie Saunders, 3500 Gaston Ave., Dallas 4, Texas, Secretary.

AMERICAN ASSOCIATION OF MEDICAL RECORD LIBRARIANS, Sheraton-Cadillac Hotel, Detroit, Oct. 4-8. Miss Doris Gleason, 510 N. Dearborn St., Chicago 10, Executive Director.

AMERICAN ASSOCIATION OF OBSTETRICIANS, GYNECOLOGISTS AND ABDOMINAL SURGEONS, The Homestead, Hot Springs, Va., Sept. 9-11. Dr. Frank R. Lock, Bowman Gray School of Medicine, Winston-Salem, N. C., Secretary.

AMERICAN CANCER SOCIETY, Hotel Roosevelt, New York, Oct. 17-24. Dr. Charles S. Cameron, 47 Beaver St., New York 4, Medical Director.

AMERICAN CLINICAL AND CLIMATOLOGICAL ASSOCIATION, Lake Placid Club, Lake Placid, N. Y., Oct. 14-16. Dr. Marshall N. Fulton, 124 Waterman St., Providence 6, R. I., Secretary.

AMERICAN CONGRESS OF PHYSICAL MEDICINE AND REHABILITATION, Hotel Statler, Washington, D. C., Sept. 6-11. Dr. Walter J. Zeiter, 30 N. Michigan Ave., Chicago 2, Executive Director.

AMERICAN FRACTURE ASSOCIATION, Shamrock Hotel, Houston, Texas, Oct. 11-14. Dr. H. W. Wellmerling, 626 Griesheim Bldg., Bloomington, Ill., Secretary-General.

AMERICAN HOSPITAL ASSOCIATION, Palmer House, Chicago, Sept. 13-16. Dr. E. L. Crosby, 18 East Division St., Chicago 10, Director.

AMERICAN MEDICAL WRITERS' ASSOCIATION, Hotel Sherman, Chicago, Sept. 24. Dr. Harold Swanberg, 510 Maine St., Quincy, Ill., Secretary.

AMERICAN OTORHINOLOGIC SOCIETY FOR PLASTIC SURGERY, The Waldorf-Astoria, New York, Sept. 19. Dr. Louis J. Feit, 66 Park Ave., New York, Secretary.

AMERICAN PUBLIC HEALTH ASSOCIATION, Memorial Auditorium, Buffalo, N. Y., Oct. 11-15. Dr. Reginald M. Atwater, 1790 Broadway, New York 19, Executive Secretary.

AMERICAN ROENTGEN RAY SOCIETY, Shoreham Hotel, Washington, D. C., Sept. 21-24. Dr. Barton R. Young, Germantown Hospital, Philadelphia 44, Secretary.

AMERICAN SOCIETY OF CLINICAL PATHOLOGISTS, Shoreham Hotel, Washington, D. C., Sept. 6. Dr. Clyde G. Culbertson, 1040-1232 W. Michigan St., Indianapolis, Secretary.

ASSOCIATION OF LIFE INSURANCE MEDICAL DIRECTORS OF AMERICA, Royal York Hotel, Toronto, Canada, Oct. 13-15. Dr. Henry B. Kirkland, P. O. Box 594, Newark, N. J., Secretary.

ASSOCIATION OF AMERICAN MEDICAL COLLEGES, French Lick Springs Hotel, French Lick, Ind., Oct. 17-20. Dr. Dean F. Smiley, 185 N. Wabash Ave., Chicago 1, Secretary.

CENTRAL ASSOCIATION OF OBSTETRICIANS AND GYNECOLOGISTS, Hotel Jefferson, St. Louis, Oct. 7-9. Dr. Harold L. Gainey, Suite 602, 116 S. Michigan Ave., Chicago 3, Secretary.

CLINICAL ORTHOPAEDIC SOCIETY, Sheraton Hotel, Chicago, Oct. 7-9. Dr. John H. Moe, 825 Nicollet Ave., Minneapolis, Secretary.

COLLEGE OF AMERICAN PATHOLOGISTS, The Shoreham, Washington, D. C., Sept. 6. Dr. Arthur H. Dearing, 203 N. Wabash Ave., Chicago 1, Executive Secretary.

COLORADO STATE MEDICAL SOCIETY, Broadmoor Hotel, Colorado Springs, Sept. 21-24. Mr. Harvey T. Sethman, 835 Republic Building, Denver 2, Executive Secretary.

DELAWARE, MEDICAL SOCIETY OF, Dover, Oct. 11-13. Dr. Norman L. Cannon, 1208 Delaware Ave., Wilmington, Executive Secretary.

GULF COAST CLINICAL SOCIETY, Edgewater Park, Miss., Oct. 21-22. Dr. F. C. Minkler, Pascagoula, Miss., Secretary.

INDUSTRIAL HEALTH CONFERENCE (Houston), Shamrock Hotel, Houston, Tex., Sept. 23-25. Dr. Sidney Schnur, 411 Medical Arts Bldg., Houston 2, Tex., Chairman.

KANSAS CITY SOUTHWEST CLINICAL SOCIETY, Kansas City, Mo., Oct. 4-7. Dr. Ira C. Layton, 306 E. Twelfth St., Kansas City 6E, Mo., Secretary.

KENTUCKY STATE MEDICAL ASSOCIATION, Brown Hotel, Louisville, Sept. 21-23. Dr. Bruce Underwood, 620 S. Third St., Louisville 2, Secretary.

MICHIGAN STATE MEDICAL SOCIETY, Sheraton-Cadillac Hotel, Detroit, Sept. 29-Oct. 1. Dr. L. Fernald Foster, 606 Townsend St., Lansing 15, Secretary.

MISSISSIPPI VALLEY MEDICAL SOCIETY, Hotel Sherman, Chicago, Sept. 22-24. Dr. Harold Swanberg, 510 Maine St., Quincy, Ill., Secretary.

MONTANA MEDICAL ASSOCIATION, Hotel Finlen, Butte, Sept. 16-19. Mr. L. R. Hegland, 1236 N. 28th St., Billings, Executive Secretary.

NATIONAL ASSOCIATION FOR MENTAL HEALTH, Hotel Statler, New York, Oct. 23-Nov. 2. Mr. Robert M. Heininger, 1790 Broadway, New York 19, Executive Director.

NATIONAL PROCTOLOGIC ASSOCIATION, Maryland Hotel, Chicago, Oct. 7-9. Dr. George E. Mueller, 59 E. Madison St., Chicago 2, Executive Secretary.

NEW HAMPSHIRE MEDICAL SOCIETY, Mt. Washington Hotel, Bretton Woods, Oct. 3-5. Dr. W. H. Butterfield, 18 School St., Concord, Secretary.

NORTHERN MINNESOTA MEDICAL ASSOCIATION, Willmar, Sept. 10-11. Dr. C. L. Oppegaard, Crookston, Secretary.

OREGON STATE MEDICAL SOCIETY, Heathman Hotel, Portland, Oct. 13-16. Dr. Charles E. Littlehales, 1115 S. W. Taylor St., Portland 5, Executive Secretary.

PACIFIC DERMATOLOGIC ASSOCIATION, Broadmoor Hotel, Colorado Springs, Colo., Sept. 2-4. Dr. Ben A. Newman, 436 N. Roxbury Drive, Beverly Hills, Calif., Secretary.

PENNSYLVANIA, MEDICAL SOCIETY OF THE STATE OF, Bellevue-Stratford Hotel, Philadelphia, Oct. 17-22. Dr. Harold B. Gardner, 230 State St., Harrisburg, Secretary.

REGIONAL MEETINGS, AMERICAN COLLEGE OF PHYSICIANS:
Bismarck, N. D., Sept. 11. Dr. Robert B. Radl, 221 Fifth St., Bismarck, N. D., Governor.
Midwest, Indianapolis, Claypool Hotel, Oct. 9. Dr. Wendell A. Shullenberger, 3470 Central Ave., Indianapolis, Chairman.
New England, Hartford, Conn., Oct. 22. Dr. John C. Leonard, 80 Seymour St., Hartford, Conn., Chairman.
Southeastern, Edgewater Gulf Hotel, Edgewater Park, Miss., Oct. 15-16. Dr. E. Dice Lineberry, 1529 N. 25th St., Birmingham 4, Ala., Governor.

SOUTHWESTERN SURGICAL CONGRESS, Skirvin Hotel, Oklahoma City, Sept. 20-22. Dr. C. R. Rountree, 1227 Classen Drive, Oklahoma City 3, Secretary.

THE CONSTANTINIAN SOCIETY, The Broadmoor, Colorado Springs, Colo., Sept. 26-29. Dr. C. F. Shook, P. O. Box 1035-36, Toledo 1, Ohio, Secretary.

U. S. CHAPTER, INTERNATIONAL COLLEGE OF SURGEONS, Chicago, Sept. 7-10. Dr. Karl Meyer, 1516 Lake Shore Dr., Chicago, Secretary.

VERMONT STATE MEDICAL SOCIETY, Mt. Washington Hotel, Bretton Woods, N. H., Oct. 3-5. Dr. James P. Hammond, 337 South St., Bennington, Secretary.

WASHINGTON STATE MEDICAL ASSOCIATION, Davenport Hotel, Spokane, Sept. 18-22. Dr. Bruce Zimmerman, 1309 Seventh Ave., Seattle 1, Secretary.

WESTERN ASSOCIATION OF RAILWAY SURGEONS, Sun Valley, Idaho, Sept. 23-25. Dr. Leo L. Stanley, 1322 Fifth Ave., San Rafael, Calif., Secretary.

WISCONSIN, STATE MEDICAL SOCIETY OF, Hotel Schroeder, Milwaukee, Oct. 5-7. Mr. Charles H. Crownhart, 704 E. Gorham St., Madison 3, Secretary.

FOREIGN AND INTERNATIONAL

COMMONWEALTH HEALTH AND TUBERCULOSIS CONFERENCE, Royal Festival Hall, London, England, June 21-25, 1955. Mr. J. H. Harley Williams, Tavistock House North, Tavistock Square, London, W.C.1, England, Secretary General.

CONFERENCE OF INTERNATIONAL UNION AGAINST TUBERCULOSIS, Madrid, Spain, Sept. 26-Oct. 2, 1954. Secretariat, Escuela de Tisiologia, Ciudad Universitaria, Madrid, Spain.

CONFERENCE OF THE SOLVAY INSTITUTE OF SOCIOLOGY, Universiti Libre de Bruxelles, Brussels, Belgium, Oct. 18-23, 1954. For information write: Assistant to the Secretary, A. Dorsinfang Smets, Solvay Institute of Sociology, Parc Leopold, Brussels 4, Belgium.

CONGRESS OF INTERNATIONAL ASSOCIATION OF APPLIED PSYCHOLOGY, London, England, July 18-23, 1955. Dr. C. B. Frisby, National Institute of Industrial Psychology, 14 Welbeck St., London, W.1, England, President.

CONGRESS OF INTERNATIONAL ASSOCIATION FOR THE PREVENTION OF BLINDNESS, New York, N. Y., U. S. A., Sept. 12-17, 1954. Professor Franceschetti, 2 avenue Mirmot, Geneva, Switzerland, Secretary-General.

CONGRESS OF THE INTERNATIONAL DIABETES FEDERATION, Cambridge, England, July 4-8, 1955. Mr. James G. L. Jackson, 152 Harley St., London, W.1, England, Executive Secretary General.

CONGRESS OF INTERNATIONAL SOCIETY OF MEDICAL HYDROLOGY, Vichy, Paris, and Enghien, France, Sept. 24-27, 1954. Dr. Francon, 55, rue des Mathurins, Paris 8e, France, Secretary-General.

HEALTH CONGRESS OF THE ROYAL SANITARY INSTITUTE, Bournemouth, England, April 26-29, 1955. Mr. P. Arthur Wells, Royal Sanitary Institute, 90 Buckingham Palace Road, London, S.W.1, England, Secretary.

INTER-AMERICAN CONGRESS OF RADIOLOGY, Shoreham Hotel, Washington, D. C., U. S. A., April 24-29, 1955. Dr. Eugene P. Pendergrass, 3400 Spruce St., Philadelphia 4, Pa., U. S. A., Secretary-General.

INTER-AMERICAN SESSION, AMERICAN COLLEGE OF SURGEONS, Universidad Mayor de San Marcos de Lima, Lima, Peru, S. A., Jan. 11-14, 1955. Dr. Michael L. Mason, 40 East Erie St., Chicago 11, Ill., U. S. A., Secretary.

INTERNATIONAL ANATOMICAL CONGRESS, Paris, France, July 25-30, 1955. Prof. Gaston Cordier, 45, Rue des Saints-Peres, Paris 6e, France, Secretary-General.

INTERNATIONAL ANESTHESIA RESEARCH SOCIETY, Ambassador Hotel, Los Angeles, Calif., U. S. A., Oct. 10-14, 1954. For information write: Dr. T. H. Seldon, 102-110 Second Avenue S.W., Rochester, Minn., U. S. A.

INTERNATIONAL CONGRESS OF CLINICAL PATHOLOGY, Washington, D. C., U. S. A., Sept. 6-10, 1954. Dr. Robert A. Moore, University of Pittsburgh, Schools of the Health Profession, Pittsburgh 13, Pa., U. S. A., Chairman, Committee on Arrangements.

INTERNATIONAL CONGRESS OF COMPARATIVE PATHOLOGY, Lausanne, Switzerland, May 26-31, 1955. Professor Hauduroy, 19 rue Cesar Roux, Lausanne, Switzerland, Secretary-General.

INTERNATIONAL CONGRESS ON DISEASES OF THE CHEST, Barcelona, Spain, Oct. 4-8, 1954. Mr. Murray Kornfeld, 112 East Chestnut St., Chicago 11, Ill., U. S. A., Executive Secretary.

INTERNATIONAL CONGRESS OF HEMATOLOGY, Paris, Sept. 6-11, 1954. Dr. Jean Bernard, 86 rue d'Assas, Paris 6e, France, Secretary.

INTERNATIONAL CONGRESS OF THE HISTORY OF MEDICINE, Rome and Salerno, Italy, Sept. 13-20, 1954. For information write: Segreteria XIV Congresso Internazionale di Storia della Medicina, Instituto di Storia della Medicine, Citta Universitaria, Rome, Italy.

INTERNATIONAL CONGRESS OF HYDATID DISEASE, Madrid, Spain, Sept. 25-30, 1954. Dr. Jesus Calvo Melendro, Hospital Provincial, Sorea, Spain, Secretary-General.

INTERNATIONAL CONGRESS OF INDUSTRIAL MEDICINE, Naples, Italy, Sept. 13-19, 1954. Professor Scipione Cacciuri, Director, Institute of Industrial Medicine Policlinico, Naples, Italy, Chairman, Organizing Committee.

INTERNATIONAL CONGRESS OF INTERNAL MEDICINE, Stockholm, Sweden, Sept. 15-18, 1954. Professor Anders Kristenson, Karolinska Sjukhuset, Stockholm 60, Sweden, Secretary-General.

INTERNATIONAL CONGRESS OF MILITARY MEDICINE AND PHARMACY, Luxemburg, Luxemburg, Nov. 7-12, 1954. Colonel A. R. Vernengo, Direcion General de Sanidad Militar, Pozos 2045, Buenos Aires, Argentina, S. A., Secretary-General.

INTERNATIONAL CONGRESS OF NUTRITION, Amsterdam, Netherlands, Sept. 13-17, 1954. Dr. M. van Eekelen, Centraal Instituut voor Voedingsonderzoek T.N.O., 61 Catharynesingel, Utrecht, Netherlands, General Secretary.

INTERNATIONAL CONGRESS OF OPHTHALMOLOGY, University of Montreal and McGill University, Montreal, Canada, Sept. 9-11, 1954, and Waldorf-Astoria, New York, N. Y., U. S. A., Sept. 12-17, 1954. Dr. William L. Benedict, 100 First Avenue Building, Rochester, Minn., U. S. A., Secretary-General.

INTERNATIONAL CONGRESS OF ORTHOPEDIC SURGERY AND TRAUMATOLOGY, Berne, Switzerland, Aug. 30-Sept. 3, 1954. For information write: Professor M. Dubois, Isle-Hospital, Berne, Switzerland.

INTERNATIONAL FEDERATION OF MEDICAL STUDENT ASSOCIATIONS, Rome, Italy, Oct. 1-5, 1954. Mr. Jorgen Falck Larsen, 12, Kristianiagade, Copenhagen Ø, Denmark, General Secretary.

INTERNATIONAL HOSPITAL CONGRESS, Lucerne, Switzerland, May 30-June 3, 1955. Capt. J. E. Stone, International Hospital Federation, 10 Old Jewry, London, E.C.2, England, Hon. Secretary.

INTERNATIONAL POLIOMYELITIS CONGRESS, University of Rome, Orthopedic Clinic, Rome, Italy, Sept. 6-10, 1954. Mr. Stanley E. Henwood, 120 Broadway, New York 5, N. Y., U. S. A., Executive Secretary.

INTERNATIONAL SOCIETY OF BLOOD TRANSFUSION, Paris, France, Sept. 12-19, 1954. For information write: Colonel Julliard, Société Internationale de Transfusion Sanguine, 53 boulevard Diderot, Paris 12e, France.

INTERNATIONAL SOCIETY FOR CELL BIOLOGY, Leiden, Netherlands, Sept. 1-8, 1954. Professor Peter J. Gaillard, University of Leiden, Leiden, Netherlands, Secretary.

INTERNATIONAL SOCIETY OF GEOGRAPHICAL PATHOLOGY, Washington, D. C., U. S. A., Sept. 6-10, 1954. Professor Fred C. Roulet, Hebelstrasse 24, Basel, Switzerland, Secretary-General.

INTERNATIONAL SURGICAL CONGRESS, Geneva, Switzerland, May 23-26, 1955. Dr. Max Thorek, 1516 Lake Shore Drive, Chicago, Illinois, U. S. A., Secretary-General.

JAPAN MEDICAL CONGRESS, Kyoto University and Kyoto Prefectural Medical College, Kyoto, Japan, April 1-5, 1955. Dr. Mitsuharu Goto, University Hospital, Medical Faculty of Kyoto University, Kyoto, Japan, Secretary-General.

LATIN AMERICAN CONGRESS OF ANESTHESIOLOGY, Sao Paulo, Brazil, S. A., Sept. 12-18, 1954. Dr. Zairo E. G. Vieira, Praca Floriano, 55-7°, And., Rio de Janeiro, Brazil, S. A., Secretario.

LATIN AMERICAN CONGRESS OF PHYSICAL MEDICINE, Lima, Peru, S. A., Feb. 14-19, 1955. Dr. Cassius Lopez de Victoria, 176 East 71st St., New York 21, N. Y., U. S. A., Executive Director.

MEDICAL JOURNALISM MEETING, Exposition Universelle Romaine, Rome, Italy, Sept. 30, 1954. Dr. H. Clegg, B.M.A. House, Tavistock Square, London W.C.1, England, Secretary.

MEDICAL WOMEN'S INTERNATIONAL ASSOCIATION CONGRESS, Lake Garda, Italy, Sept. 15-21, 1954. Dr. Ada Chree Reid, 118 Riverside Drive, New York 24, N Y., U. S. A., President.

PAN AMERICAN HOMEOPATHIC MEDICAL CONGRESS, Hotel Gloria, Rio de Janeiro, Brazil, S. A., Oct. 2-13, 1954. Dr. Paul S. Schantz, 103 West Main St., Ephrata, Pa., U. S. A., Executive Secretary.

PAN-PACIFIC SURGICAL CONGRESS, Honolulu, Hawaii, Oct. 7-18, 1954. Dr. F. J. Pinkerton, Suite 7, Young Bldg., Honolulu 13, Hawaii, Director General.

WORLD CONGRESS OF CARDIOLOGY, Washington, D. C., U. S. A., Sept. 12-18, 1954. Dr. L. W. Gorham, 44 East 23d St., New York 10, N. Y., U. S. A., Secretary-General.

WORLD CONGRESS OF INTERNATIONAL SOCIETY FOR THE WELFARE OF CRIPPLES, Scheveningen-The Hague, Netherlands, Sept. 13-17, 1954. Secretariat: Miss H. P. Post, Pieter Lastmarkade 37, Amsterdam Z, Netherlands.

WORLD MEDICAL ASSOCIATION, Rome, Italy, Sept. 26-Oct. 2, 1954. Dr. Louis H. Bauer, 345 East 46th St., New York 17, N. Y., U. S. A., Secretary-General.

EXAMINATIONS AND LICENSURE

EXAMINING BOARDS IN SPECIALTIES

AMERICAN BOARD OF DERMATOLOGY AND SYPHILOLOGY: *Written.* Various centers, Sept. 2. *Oral.* Ann Arbor, Oct. 15-18. To be eligible candidates must have completed thirty-six months of training by October 1. Final date for filing application was May 1. Exec. Sec., Miss Janet Newkirk, 129 E. 52nd St., New York 22.

AMERICAN BOARD OF INTERNAL MEDICINE: *Oral.* New York, Sept. 22-24 (candidates on the east coast). The closing date for acceptance of applications was April 1. *Written.* Oct. 18. Final date for acceptance of applications was May 1. *Subspecialties. Allergy.* New York, Sept. 23 and *Pulmonary Disease.* New York, Sept. 24. Closing date for acceptance of applications was May 10. Exec. Sec.-Treas., Dr. William A. Werrell, One West Main St., Madison 3, Wis.

AMERICAN BOARD OF NEUROLOGICAL SURGERY: *Oral.* New Haven, November. Final date for filing application is November 1. Sec., Dr. Leonard T. Furlow, 600 S. Kingshighway, St. Louis 10.

AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY: *Part I.* Various Centers, Feb. 4. *Part II,* Chicago. Deadline for receipt of applications is October 1. Sec., Dr. Robert L. Faulkner, 2105 Adelbert Road, Cleveland 6.

AMERICAN BOARD OF OPHTHALMOLOGY: *Practical examinations, 1954.* New York City, Dec. 5-9. Final date for filing applications was July 1, 1953. *Written, 1955.* Various cities, Jan. 24-25. Final date for filing application was July 1, 1954. *Practical examinations, 1955.* Philadelphia, June 10-15, Chicago, Oct. 9-14. Sec., Dr. Edwin B. Dunphy, 56 Ivie Road, Cape Cottage, Maine.

AMERICAN BOARD OF ORTHOPAEDIC SURGERY: *Oral and Written.* Los Angeles, Jan. 26-28. Final date for filing applications for Part II is Aug. 15. Sec., Dr. Harold A. Sofield, 122 South Michigan Ave., Chicago 3, Ill.

AMERICAN BOARD OF OTOLARYNGOLOGY. New York City, Sept 13-17; Richmond, Va., March 6-10, 1955. Sec., Dr. Dean M. Lierle, University Hospital, Iowa City.

AMERICAN BOARD OF PATHOLOGY. Miami, Nov. 29-30-Dec. 1. Sec., Dr. William B. Wartman, 303 E. Chicago Ave., Chicago 11.

AMERICAN BOARD OF PEDIATRICS: *Oral.* Chicago, Oct. 8-10 and New Haven, Dec. 3-5. Ex. Sec., Dr. John McK. Mitchell, 6 Cushman Road, Rosemont, Pa.

AMERICAN BOARD OF PHYSICAL MEDICINE AND REHABILITATION. *Oral and Written.* Washington, D. C., Sept. 5-6. Final date for filing applications was March 31. Sec., Dr. Earl C. Elkins, 30 N. Michigan Ave., Chicago.

AMERICAN BOARD OF PLASTIC SURGERY. Atlanta, Ga., Oct. 20-22. Final date for filing case reports was June 1. Final date for filing case reports for spring 1955 examination is Jan. 1. Corres. Sec., Miss Estelle E. Hillerich, 4647 Pershing Ave., St. Louis 8.

AMERICAN BOARD OF PREVENTIVE MEDICINE: *Parts 1 and 2.* Buffalo, Oct. 9-11. Final date for filing applications was July 15. Sec., Dr. Ernest L. Stebbins, 615 N. Wolfe St., Baltimore.

AMERICAN BOARD OF PROCTOLOGY. *Part II.* Philadelphia, Sept. 25-26. *Examination in Proctology and Anorectal Surgery.* Sec., Dr. Stuart T. Ross, 131 Fulton Ave., Hempstead, New York.

AMERICAN BOARD OF PSYCHIATRY AND NEUROLOGY: New York, Dec. 13-14; New Orleans, Feb. 28-March 1, 1955; San Francisco, Mid-October, 1955; New York City, December, 1955. Sec., Dr David A. Boyd, 102-110 Second Ave. S.W., Rochester, Minnesota.

AMERICAN BOARD OF RADIOLOGY: *Oral.* Washington, D. C., September. Final date for filing application for the September examination was May 1. Sec., Dr. B. R. Kirklin, 102-110 Second Ave. S.W., Rochester, Minn.

AMERICAN BOARD OF SURGERY: *Part I.* Oct. 28; March 31 and Oct. 27, 1954. *Part II.* New York, Oct. 12-13; Chicago, Nov. 9-10; St. Louis, Dec. 14-15; Los Angeles, Jan. 11-12, Galveston, Jan. 15-16; Washington, Feb. 8-9; Cincinnati, March 8-9; New Orleans, April 12-13; Philadelphia, May 10-11 and Boston, June 14-15. Sec., Dr. John B. Flick, 225 S. 15th St., Philadelphia 2.

DEATHS

Alexander, John ● Ann Arbor, Mich.; born in Philadelphia Feb. 24, 1891; University of Pennsylvania School of Medicine, Philadelphia, 1916; at one time on surgical and teaching staff at his alma mater; professor of surgery at the University of Michigan Medical School; served in France during World War I; member of the founders group of the American Board of Surgery and that of the Central Surgical Association; member of the American Surgical Association, Society of Clinical Surgery, International Society of Surgery, Michigan Trudeau Society, Alpha Omega Alpha, Alpha Mu Pi Omega, Sigma Xi, Phi Kappa Phi, and Delta Tau Delta; honorary member of Nu Sigma Nu, Detroit Academy of Surgery, Society of Thoracic Surgery of Great Britain and Ireland, Sociedad Argentina de Cirujanos, and Société Belge de Chirurgie; past president of the American Association for Thoracic Surgery; a director, 1941-1945, of the National Tuberculosis Association and in 1945 vice-president; at one time trustee, vice-president, and president, Michigan Tuberculosis Association; and at one time president-elect of the American Trudeau Society; fellow of the American College of Surgeons; awarded the Samuel D. Gross prize of the Philadelphia Academy of Surgery in 1925, Henry Russel award of the University of Michigan in the year 1928-1929, and the Trudeau medal of the National Tuberculosis Association in 1941; in 1944 was selected as the Russel lecturer at the University of Michigan; chief surgeon at the Michigan State Sanatorium at Howell; surgeon in charge, section on thoracic surgery, University Hospital; author of "The Surgery of Pulmonary Tuberculosis" and "The Collapse Therapy of Pulmonary Tuberculosis"; member of the advisory editorial boards of *The Journal of Thoracic Surgery, Archives Médico-Chirurgicales de l'Appareil Respiratoire, Revista Española de Tuberculosis,* and the *International Abstract of Surgery;* in 1940 received the honorary degree of doctor of science from the University of Pennsylvania; died in the University Hospital July 16, aged 63, of gastrointestinal hemorrhage.

Dittrick, Howard ● Cleveland Heights, Ohio; born in St. Catharine's, Ontario, Canada, in 1877; University of Toronto Faculty of Medicine, Toronto, Canada, 1900; past president of the Cleveland Medical Library Association; in 1927 became trustee of the library, serving for a time as director of membership and director of programs; founder, in 1928 became curator, and in 1935 director of its Museum of Historical and Cultural Medicine, which in 1945 was named the Howard Dittrick Museum of Historical Medicine in his honor; for many years on the membership committee of the Academy of Medicine of Cleveland, chairman of the clinical pathological section and of the program committee, director and chairman of the publication committee, and advisory editor of the *Bulletin of the Academy of Medicine of Cleveland;* in 1943 was presented with the academy's distinguished service award; in June, 1941, received a special certificate of merit from the American Medical Association for his historical exhibit; past president of the Cleveland Medical Examiners Society; formerly on the faculty of Western Reserve University School of Medicine; served as professor of historical medicine at the Frank E. Bunts Educational Institute, where he served as secretary; represented the U. S. government as a delegate to the International Congress of History of Medicine in Spain in 1935 and in Yugoslavia in 1938; editor of *Current Researches in Anesthesia and Analgesia;* in 1943 appointed editorial director of the Cleveland Clinic Foundation; author of two books; member of the Cleveland Museum of Art and chairman of an intermuseum advisory group in Cleveland; died in the Cleveland Clinic Hospital July 11, aged 77, of carcinoma of the colon.

Kosinak, George William ● New York City; born in New York July 24, 1873; Columbia University College of Physicians and Surgeons, New York, 1899; specialist certified by the American Board of Obstetrics and Gynecology; member of the American Gynecological Society, of which he was past treasurer, vice-president, and president; fellow and formerly governor of the American College of Surgeons; member of the House of Delegates of the American Medical Association in 1918-1919 and from 1934 to 1953 inclusive; past president of the New York Obstetrical Society; past president and treasurer of the Medical Society of the County of New York; formerly treasurer of the Medical Society of the State of New York; formerly secretary of the advisory obstetric council, New York City Department of Health, and consultant in obstetrics for the New York State Board of Health; for many years member of the board of directors of the Maternity Center Association, serving as chairman of the medical board for 19 years; attending surgeon, Lying-In Hospital of New York, from 1905 to 1926; medical director emeritus at the William Booth Memorial Hospital; founder of the *American Journal of Obstetrics and Gynecology,* editor in chief for 33 years, since 1953 served as an advisor; the July issue of the journal was published as a Festschrift in his honor; member of the publication committee and editor of the *New York State Journal of Medicine;* editor of the *Transactions of the International and Fourth American Congress on Obstetrics and Gynecology;* author of "Toxemias of Pregnancy"; died July 10, aged 80.

McGraw, Arthur Butler ● Detroit; born in Detroit Oct. 27, 1893; Columbia University College of Physicians and Surgeons, New York, 1919; associate professor of surgery (oncology) at Wayne University College of Medicine; member of the founders group of the American Board of Surgery; member of the American Surgical Association, Western Surgical Association, Central Surgical Association, Société Internationale de Chirurgie, and the Detroit Surgical Society; fellow of the American College of Surgeons, New York Academy of Medicine, and Detroit Academy of Surgery; trustee of the American Cancer Society, the Michigan Children's Aid Society, and the Boys' Republic; during World War I served as a private in the Medical Corps of the U. S. Army and in World War II was on active duty with the U. S. Navy from 1942 to 1946, rising to the rank of captain; from 1922 to 1927 junior surgeon at the Henry Ford Hospital, where he was associate surgeon since 1928 and in charge of the tumor clinic since 1932; died June 18, aged 60, of carcinoma of the stomach.

Gerstenberger, Henry John ● Cleveland; born in Cleveland Jan. 9, 1881; Western Reserve University Medical Department, Cleveland, 1903; professor emeritus of pediatrics at his alma mater; specialist certified by the American Board of Pediatrics; member of the American Pediatric Society, American Academy of Pediatrics, and the American Public Health Association; headed the American delegation to the International Congress for Protection of Childhood in Rome in 1937; honorary member of the German Pediatric Society; affiliated with the Rainbow Hospital for Crippled and Convalescent Children in South Euclid and with the City Hospital; instrumental in founding Babies and Childrens Hospital, where he was the first director of pedlatrics; died in University Hospitals June 24, aged 73, of myocardial infarction and carcinoma of the prostate.

Alexander, John Harrison ● Pittsburgh; born in New Castle, Pa., Oct. 30, 1887; University of Pennsylvania School of Medicine, Philadelphia, 1912; member of the founders group of the American Board of Surgery; member of the American Association for the Surgery of Trauma and the American Association of Railway Surgeons; fellow of the American College of Surgeons; past president of the Pittsburgh Surgical Society; served overseas during World War I; company surgeon for the Pennsylvania Railroad; for many years on the staff of the Allegheny General Hospital, where he died May 31, aged 66, of cirrhosis of the liver.

Ebright, George Elliott ● San Francisco; born in Corvallis, Ore., May 18, 1873; Medical Department of the University of California, San Francisco, 1899; specialist certified by the American Board of Internal Medicine; associate clinical professor of medi-

● Indicates Member of the American Medical Association.

cine, emeritus, at his alma mater; past president of the California Medical Association; for many years president of the state board of health; advisor on the California State Council of Defense during World War II; on the staffs of St. Francis, Stanford University, and University of California hospitals; died June 26, aged 81, of arteriosclerosis and coronary disease.

Abrams, Mark Philip, Chicago; St. Louis College of Physicians and Surgeons, 1919; affiliated with the American Hospital, where he died July 20, aged 68, of encephalomalacia.

Adamson, James Edward, Doniphan, Mo.; Drake University College of Medicine, Des Moines, 1904; died in Fredericktown, July 2, aged 77, of coronary occlusion.

Aldrich, J. Frank ✪ Decatur, Ill.; Rush Medical College, Chicago, 1897; member of the Iowa State Medical Society; formerly practiced in Shenandoah, Iowa, where he was city health officer, member of the board of education, and a trustee of the public library; a member of the state board of health of Iowa, 1933-1934; for many years on the staff of Mental Health Institute of Clarinda, Iowa; died July 8, aged 81, of carcinoma of the stomach.

Ansfield, Maurice Joseph ✪ Milwaukee; University of Wisconsin Medical School, Madison, 1932; clinical instructor in medicine at the Marquette University School of Medicine; at one time part-time deputy superintendent of the bureau of contagious diseases and school hygiene of the city health department; served during World War II; fellow of the American College of Physicians; on the staff of the Milwaukee County General Hospital and Mount Sinai Hospital, where he died May 26, aged 46, of lymphosarcoma of the stomach.

Arthur, Hamilton M. ✪ Hazleton, Ind.; Medical College of Indiana, Indianapolis, 1898; served as bank president; died in the Gibson General Hospital, Princeton, June 1, aged 81, of uremia and chronic nephritis.

Basile, Frank, New York City; University and Bellevue Hospital Medical College, New York, 1909; on the staff of the Columbus Hospital; died June 11, aged 70.

Beattie, John ✪ Norfolk, Va.; University of Pennsylvania Department of Medicine, Philadelphia, 1895; served during World War I; at one time practiced in Lebanon, Pa., where he was affiliated with the Good Samaritan Hospital; died in Virginia Beach June 1, aged 85.

Benning, Henry Millard ✪ Santa Barbara, Calif.; Columbia University College of Physicians and Surgeons, New York, 1929; specialist certified by the American Board of Internal Medicine; served during World War II; on the staff of the Santa Barbara General Hospital; affiliated with Cottage and St. Francis hospitals; died June 19, aged 50, of multiple sclerosis.

Bohannon, George Harvey, Louisville, Ky.; Kentucky School of Medicine, 1904; died in St. Joseph Infirmary June 21, aged 73, of hemorrhage from esophageal varices and cirrhosis of the liver.

Boulton, Arthur O. ✪ Gladwin, Mich.; Detroit College of Medicine, 1900; died May 13, aged 79, of myocarditis.

Boyd, Robert Tilford ✪ San Francisco; University of California Medical School, San Francisco, 1926; specialist certified by the American Board of Orthopedic Surgery; served during World Wars I and II; affiliated with St. Francis, French, Mary's Help, and St. Luke's hospitals; died May 6, aged 57, of arteriosclerotic heart disease.

Boyer, Arthur Truman, Philadelphia; University of Pennsylvania Department of Medicine, Philadelphia, 1901; for many years on the staff of the Mercy Hospital; died in the Hospital of the University of Pennsylvania July 14, aged 80, of cerebral thrombosis.

Bracken, Lawson E., Columbus, Ind.; Homeopathic Medical College of Missouri, St. Louis, 1903; died June 3, aged 86, of cerebral hemorrhage.

Brady, George Thomas, San Francisco; Cooper Medical College, San Francisco, 1897; served on the staffs of Mary's Help and Stanford University hospitals; died in Notre Dame Hospital May 19, aged 80, of arteriosclerosis.

Bremer, Joseph Peter ✪ Point Cedar, Ark.; University of Arkansas School of Medicine, Little Rock, 1915; died in Hot Springs National Park June 12, aged 68, of arteriosclerosis.

Brown, J. Samuel ✪ Ghent, Ky.; University of Louisville (Ky.) Medical Department, 1892; a charter member and past president of the Tri-County Medical Society, consisting of Carroll, Gallatin, and Trimble counties; chairman of the Tri-County Board of Health; in 1948 received the distinguished service medal awarded annually by the Kentucky State Medical Association; died July 1, aged 83.

Butler, Thomas, St. Francisville, La.; Medical Department of Tulane University of Louisiana, New Orleans, 1902; served as coroner; died in Baton Rouge General Hospital June 4, aged 75, of coronary thrombosis.

Byrns, Robert Emmett ✪ St. Louis; Barnes Medical College, St. Louis, 1911; served during World War I; died in Chicago July 5, aged 67, of organic heart disease.

Chatham, Edgar Thomas ✪ Polk, Pa.; University of Pittsburgh School of Medicine, 1909; served overseas during World War I; formerly practiced in Pittsburgh, where he was on the staffs of the Allegheny General Hospital and the Reformed Presbyterian Home for Aged; on the staff of the Polk State School; died in Pittsburgh June 16, aged 70, of coronary occlusion.

Clark, Walden Allen ✪ Pittsburgh; Starling Medical College, Columbus, 1900; served during World War I; died June 10, aged 76.

Clemons, Ezra Jay ✪ Los Angeles; College of Physicians and Surgeons of Chicago, School of Medicine of the University of Illinois, 1902; an Associate Fellow of the American Medical Association; member of the American Proctologic Society; served on the staff of the Los Angeles County General Hospital, where he died June 22, aged 76, of cerebral thrombosis.

Coffey, Alden ✪ Fort Worth, Texas; Vanderbilt University School of Medicine, Nashville, Tenn., 1906; fellow of the American College of Surgeons; on the staff of St. Joseph's Hospital; died May 26, aged 70.

Colloten, Frank Bernard, Boston; Middlesex College of Medicine and Surgery, Cambridge, Mass., 1916; served on the staffs of the Beth Israel and Massachusetts General hospitals; died July 5, aged 71.

Colvin, Ainsley Richard ✪ Strong, Ark; Memphis (Tenn.) Hospital Medical College, 1895; served as mayor, city clerk, councilman, and health officer at Strong; formerly El Dorado city health officer; died May 29, aged 83, of nephrosclerosis.

Comfort, Harold Wesley ✪ Fortuna, Calif.; University of California Medical School, San Francisco, 1925; high school trustee; served during World War I; on the staff of Scotia (Calif.) Hospital; died June 17, aged 60, of congestive heart failure.

Corry, Earle Harrison ✪ Pueblo, Colo.; Milwaukee Medical College, 1912; member of the American Academy of Dermatology and Syphilology; served on the staff of Corwin Hospital, where he died May 18, aged 64, of cerebral thrombosis.

Covey, William Crocket ✪ Beckley, W. Va.; University of Maryland School of Medicine and College of Physicians and Surgeons, Baltimore, 1917; served overseas during World War I; died May 19, aged 61, of myocardial insufficiency.

Crouch, Myrix J., Union, Ky.; University of Louisville Medical Department, 1887; died June 29, aged 89.

Davis, Edward Griffith ✪ Belvidere, Ill.; Bennett College of Eclectic Medicine and Surgery, Chicago, 1900; College of Physicians and Surgeons of Chicago, School of Medicine of the University of Illinois, 1902; died in the Highland Hospital June 19, aged 83, of prostatic hypertrophy and coronary thrombosis.

Davis, Tom Lloyd II ✪ Wadena, Minn.; University of Minnesota Medical School, Minneapolis, 1946; affiliated with Wesley Hospital; died near Paynesville April 25, aged 31, of injuries received in an automobile accident.

Deatherage, William ✪ Dallas, Texas; Eclectic Medical Institute, Cincinnati, 1886; Marion-Sims College of Medicine, St. Louis, 1895; died June 10, aged 93, of cerebral thrombosis and arteriosclerosis.

Derickson, Elvia Clair, Burlington, Mich.; University of Michigan Department of Medicine and Surgery, Ann Arbor, 1901; for many years township health officer; died June 21, aged 81, of coronary thrombosis.

Dick, Alfred Carr, Los Angeles, Calif.; University of Chicago, School of Medicine, 1932; died in the Good Samaritan Hospital July 2, aged 48, of bronchopneumonia.

Dworzak, Zdenko V. de, Santa Barbara, Calif.; Medizinische Fakultät der Universität, Vienna, Austria, 1903; died in Santa Monica June 19, aged 78.

Eddy, Stanton Seely Jr. ✦ Middlebury, Vt.; University of Vermont College of Medicine, Burlington, 1931; member of the American Academy of General Practice; died June 18, aged 48, of brain tumor.

Erwin, Para F., Wellston, Okla.; University Medical College of Kansas City, Mo., 1910; died in the Wesley Hospital, Oklahoma City, June 10, aged 74, of adenocarcinoma of the esophagus.

Fein, Jack ✦ New York City; University of Maryland School of Medicine and College of Physicians and Surgeons, Baltimore, 1932; assistant in gynecology at the Bronx Hospital; died June 28, aged 48, of acute coronary occlusion.

Fuson, Amandus U., San Francisco; College of Physicians and Surgeons of Chicago, School of Medicine of the University of Illinois, 1898; died June 2, aged 85, of cardiac tamponade and rupture of dissecting aneurysm of the aorta.

Ganoe, Charles Virgil, El Monte, Calif.; College of Physicians and Surgeons of Chicago, School of Medicine of the University of Illinois, 1905; died June 15, aged 72, of cerebrovascular accident due to generalized arteriosclerosis.

Grady, Thomas Francis, Lynn, Mass.; Harvard Medical School, Boston, 1912; died in the Massachusetts Memorial Hospital, Boston, June 17, aged 67, of cerebral vascular accident and acute hepatitis.

Hanby, Forwood Evans ✦ Jenkintown, Pa.; Hahnemann Medical College and Hospital of Philadelphia, 1922; affiliated with the Abington (Pa.) Memorial Hospital, where he was in the urology department, and formerly associated with Wills and Episcopal hospitals in Philadelphia; died March 9, aged 60.

Harrell, William Horace ✦ Creswell, N. C.; Jefferson Medical College of Philadelphia, 1925; served on the staff of Chowan Hospital, Edenton; died June 11, aged 52, of cerebral hemorrhage.

Havenner, George Clement, Vienna, Va.; Howard University College of Medicine, Washington, D. C., 1888; died June 11, aged 87, of hypertensive heart disease.

Heaton, Dwight Ruggles Perry, Fort Lauderdale, Fla.; Columbia University College of Physicians and Surgeons, New York, 1909; died in St. Luke's Hospital, New York, June 15, aged 69, of adenocarcinoma of the lung.

Hill, Everett Edward, Urbana, Ill.; American Medical College, St. Louis, 1905; Barnes Medical College, St. Louis, 1906; affiliated with the Burnham City Hospital, where he died June 24, aged 77.

Hughes, Henry Anderson, McKee, Ky.; University of Louisville Medical Department, 1916; served during World War I; died in the Pattie A. Clay Infirmary, Richmond, June 19, aged 73, of coronary sclerosis.

Hughes, James Vestal Jr. ✦ Savannah, Tenn.; University of Tennessee College of Medicine, Memphis, 1931; died April 25, aged 46.

Humphries, William Clayton, Acworth, Ga.; Atlanta Medical College, 1888; in 1937 resigned as health officer of the city of Griffin and Spalding County; served during World War I; died in Atlanta June 11, aged 89.

Johnson, Harold Albert, Watertown, Conn.; University of Vermont College of Medicine, Burlington, 1925; died in Waterbury Hospital June 19, aged 62, of nephritis and carcinoma of the bladder.

Kahn, Solomon Guthman ✦ Salt Lake City; University of the City of New York Medical Department, New York, 1890; fourth Vice-President of the American Medical Association in 1913-1914, and member of the House of Delegates in 1912, 1915, 1917, 1929, and 1930; formerly health commissioner; past president of the Utah State Medical Association and Salt Lake County Medical Society; member of the board of directors of the Utah State Training School at American Fork; for many years on the staff of the Holy Cross Hospital; died June 21, aged 87.

Kester, Effie Kate, Alhambra, Calif.; the Hahnemann Medical College and Hospital, Chicago, 1891; died June 17, aged 85.

Rafferty, Donald George, Pass Christian, Miss.; University of Pittsburgh School of Medicine, 1908; formerly an officer in the regular Navy; died June 11, aged 72, of bronchopneumonia, following a cerebral hemorrhage.

Shaffer, Frederick Bleecher ✦ Somerset, Pa.; University of Pennsylvania Department of Medicine, Philadelphia, 1908; served overseas during World War I; for a number of years was a member of the board of education of Somerset borough; president of the Peoples National Bank; on the staff of the Somerset Community Hospital; died June 2, aged 80, of arteriosclerosis.

Shaw, Albert Edward ✦ Des Moines, Iowa; Hahnemann Medical College and Hospital of Philadelphia, 1909; on the staff of Lutheran Hospital; died April 7, aged 73, of chronic congestive cardiac failure.

Sherwood, Andrew Jackson ✦ Union City, Pa.; University of Pennsylvania School of Medicine, Philadelphia, 1903; on the staffs of the Hamot and St. Vincent's hospitals in Erie and the Henry L. Stem Memorial Hospital; died June 18, aged 76, of arteriosclerotic heart disease.

Shirley, Reginald King, Gaithersburg, Md.; Queen's University Faculty of Medicine, Kingston, Ontario, Canada, 1923; affiliated with the Frederick (Md.) Memorial Hospital and the Washington Sanitarium and Hospital in Takoma Park, where he died June 5, aged 58, of coronary disease.

Shore, Harry, St. Louis; St. Louis College of Physicians and Surgeons, 1909; died in the Jewish Hospital June 9, aged 73, of diabetes mellitus and arteriosclerosis obliterans.

Sibbald, Malcolm Louis ✦ Dexter, Mich.; University of Manitoba Faculty of Medicine, Edmonton, Alberta, Canada, 1921; died in the University Hospital, Ann Arbor, July 3, aged 59, of a heart attack.

Treadwell, Glenn F. ✦ Friendship, Wis.; Milwaukee Medical College, 1910; on the staff of the Adams-Friendship Hospital, Adams; died in Divine Savior Hospital in Portage, June 20, aged 76, of coronary thrombosis.

Triplett, Henry Hall, Corbin, Ky.; University of Tennessee College of Medicine, Memphis, 1933; died in the Barnes Hospital, St. Louis, June 27, aged 47, of intraventricular bleeding following prefrontal lobotomy.

Van Woert, Reginald ✦ Ravena, N. Y.; Albany (N. Y.) Medical College, 1920; served as health officer of Ravena; died in New Baltimore May 5, aged 58, of coronary occlusion.

Wham, George Dorrit ✦ Del Mar, Calif.; University of Illinois College of Medicine, Chicago, 1950; member of the Illinois State Medical Society; died June 25, aged 33.

Wicker, Eli W., Brady, Texas (licensed in Texas under the Act of 1907); died June 21, aged 79.

Woodward, Ira Richard Sr. ✦ Payette, Idaho; Denver College of Medicine, 1897; past president of the state board of medical examiners; at one time member of the city council, and mayor; since 1899 district surgeon for the Union Pacific Railroad; affiliated with Holy Rosary Hospital in Ontario, Ore.; died May 28, aged 80, of chronic myocardial failure.

Zarr, Luther Lynn ✦ Houston, Texas; Tulane University of Louisiana School of Medicine, New Orleans, 1938; member of the American Academy of General Practice; died June 22, aged 43, of acute myocardial infarction.

FOREIGN LETTERS

AUSTRIA

Granulomatous Giant Cell Arteritis.—At the scientific meeting of the Society of Physicians held in Vienna on May 14, 1954, Dr. J. Zeitlhofer reported three cases of "granulomatous giant cell arteritis" (temporal arteritis). The microscopic findings, on the basis of resected portions of the superficial temporal artery, were described. Dr. A. Pillat stated that, according to his knowledge, these are the first cases of temporal arteritis reported in Austria. In one case, a 77-year-old woman complained of unbearable pain in the temples and in the occiput of two months' duration. On March 18, 1954, when she got up from bed, she found that her right eye was almost blind. Examination showed there was a papillitis of 2 D. in the right eye, swelling, and a sedimentation rate of 121. Light sensitivity following the retrobulbar injection of vasodilators was only temporary. On April 14, a portion of the right temporal artery was resected. As a result, the papilla grew paler and practical blindness occurred. The second patient, a 72-year-old woman, had severe pain in the temple, occiput, shoulders, and sacral region; this began in December, 1953. Early in February, 1954, the pain in the temples and in the cervical region became extremely severe. On March 22, 1954, she found that her left eye was almost blind. Examination revealed a moderate hypertonia of the retinal vessels, left papillitis with gray swelling of the tissue of the optic nerve, vision limited to distinguishing movement of the hand before the eye, and a sedimentation rate of 80. On April 30, a papillitis suddenly occurred in the right eye. Resection of the right temporal artery was done, but did not have any influence on the patient's vision.

The prognosis for vision in patients with temporal arteritis is nearly always bad. These patients have severe, continuous pain in the temples and the head, general weakness, temperatures ranging up to 100.4 F, a very high sedimentation rate, and rather high blood pressure. The temporal arteries are hard, tortuous, and frequently tender on palpation. The pulsation in these arteries gradually ceases. Sometimes the arteritis also involves the tongue, salivary glands, pharynx, occipital, and cervical portions of the head, and occasionally the axilla and upper extremities. The microscopic findings are those of a thrombotic arteritis with giant cell infiltration, as observed in the two patients reported on. The lesions of the eyes include papillitis and neuritis of the optic nerve or thrombosis of the central artery of the retina with resulting atrophy of the papilla associated with pronounced excavation. Practical blindness results in most of these patients. The cause of the disease is unknown.

Vagotomy for Jejunal Ulcer.—At a meeting of the Society of Physicians in Vienna on May 21, 1954, Dr. R. Oppolzer reported on vagotomy performed for peptic jejunal ulcer. The hope, current a few years ago, that vagotomy would obviate the necessity for resection in patients with ulcers was not fulfilled, and resection is still the treatment of choice. The early and late results of resection are better and more reliable than those obtained with vagotomy, and the mortality following resection in the hands of experienced surgeons is not higher than that following vagotomy. Dr. Oppolzer performs vagotomy only for: (1) peptic jejunal ulcers that develop after resection, (2) deep-seated duodenal ulcers that would be difficult to resect in patients with poor general condition who cannot be subjected to a resection or to an exclusion gastrectomy—but in such patients always combined with gastroenterostomy, and (3) gastric ulcer near the cardia (instead of a Madlenner's resection) when it may be assumed that the condition is not malignant. Satisfactory permanent results may be obtained rapidly with vagotomy in patients with peptic jejunal ulcer.

Although vagotomy has been considered by various investigators to be the method of choice in treating peptic jejunal ulcer, Dr. Oppolzer believes that resection should be performed for peptic jejunal ulcer: (1) after simple gastroenterostomy in patients whose general condition is satisfactory—three-fourths of the stomach is resected and anastomosed and vagotomy is performed later, (2) in patients with jejunocolonic fistulas, (3) in patients with recent perforation, and (4) in patients with severe hemorrhage due to erosion. Three patients with large penetrating peptic jejunal ulcers were presented along with roentgenograms taken before and three weeks after vagotomy. Complete healing could be recognized. These and six other patients were completely free of complaints on reexaminations one-half to two and one-half years after this operation and showed no evidence of recurrent ulcers.

The items in these letters are contributed by regular correspondents in the various foreign countries.

DENMARK

Hormone Treatment of Cancer of the Prostate.—At the surgical department D of the Bispebjerg Hospital 160 patients with cancer of the prostate have been treated in the period 1945 to 1950. The 43 patients given diethylstilbestrol (Stilbestrol) tablets during the years 1945, 1946, and 1947 have been the subject of a careful follow-up examination by Dr. Finn Bojsen (*Ugeskrift for laeger*, July 8, 1954). At first only 2 mg. of diethylstilbestrol were given daily, but since 1946 the dosage was greatly increased, the initial dosage being 15 mg. daily for 10 to 14 days. Thereafter the dosage was gradually reduced until only 3 to 6 mg. were given daily for an unlimited period. Several patients died within a year of starting this treatment, but it seemed to have afforded them some relief. The diagnosis of cancer was confirmed by biopsy in all the 43 patients. The first follow-up examination, in 1951, showed that 15 patients were still alive from four to six years after the institution of treatment. Twenty-two patients had died of cancer within three and one-half years, and six had died of some other cause. Between 1951 and 1953, when the final follow-up examination was made, there were four deaths the cause of which may have been cancer of the prostate, although factors such as heart disease and bronchopneumonia may have been contributory. Among the 11 surviving patients, 9 were contacted by letter and reported favorably on themselves. In Dr. Bojsen's opinion, these findings show that in many patients (with an average age of 69 years when hormone treatment is started) it is possible to add many years to the life expectancy, but the patient must continue to take diethylstilbestrol daily for the rest of his life.

Phenylbutazone.—The first publications in the Danish medical press on phenylbutazone were rather discouraging, because of the risk of agranulocytosis. The latest report suggests that this risk may be outweighed by the benefits of the drug when certain precautions are observed. In *Ugeskrift for laeger*, June 3, 1954, Dr. Kaj Jespersen gives an account of 128 patients suffering from arthroses, polyarthritis, myosis, and the like. In every patient the risks were carefully balanced against the benefits promised by this drug, and written instructions were given that included dosage and special risks. Blood counts were made a few days after treatment was begun and were repeated about once a week. In 24 patients the treatment was discontinued because of side-effects that usually involved the digestive tract, but only in 1 patient did the drug have to be discontinued because of its effects on the hematological findings. In this patient the number of blood platelets fell suddenly from 192,000 to 108,000 after about six weeks of treatment. A fortnight after the drug had been discontinued, the blood platelet count was back to 164,000. On the credit side was great relief from pain with restoration to working capacity in many patients. For the first three days two tablets of 0.2 gm. each were given twice a day; for the next three days one tablet was given three times a day; and thereafter two tablets were given daily. The usual maintenance dose was one or two tablets daily. The tablets were taken after meals with milk.

ENGLAND

The Future of Surgery.—At a meeting of the Manchester Medical Society Sir Heneage Ogilvie spoke on the future of surgery. He said that writers in the past had considered that surgery had no future; they believed that all that remained was to perfect and polish what had already been done. This is only true of operative surgery, technical skill not having improved for the last half century. During this time new operations have been devised, new regions in the body have been explored, operative results have improved, and operative mortality and morbidity have fallen. Many of the advances are due, not to surgical skill, but to advances in ancillary fields, such as anesthesia. Manual surgical skill cannot be improved very much. The important qualities in a surgeon are technical skill, knowledge, wisdom, clarity of thought, originality, leadership, integrity, courage, and humility. Skill can be increased by the division of labor in the surgical team. Preventing loss of blood by the use of hypotensive drugs is unwise, except in special or difficult operations, as it entails too great a risk of producing thrombosis in the cardiac and cerebral vessels. A systemic hemostatic that will seal cut vessels without producing clotting in intact ones and a contrast medium excreted by the pancreas are needed. The prospects of surgery as a profession in Britain are not bright under the National Health Service. The advances in the past came because the door was open to let in those on the way up, to let out those on the way down, and help those starting. Now surgery is a guaranteed career followed by those in search of security. The pre-Health Service surgeon had to make his position by his own efforts. Now the surgical aspirant walks into a hospital as a resident and walks out a specialist. The present system does not recognize that the surgeon acquires his skill and knowledge slowly, progressively, and by prolonged apprenticeship.

Registration of Overseas Practitioners.—The General Medical Council at its meeting on May 25 considered the figures relative to overseas physicians. Since the beginning of last year, practitioners holding recognized overseas commonwealth and other diplomas who wish to obtain full registration in this country have had to furnish the council with evidence that they have had such internship as is required of applicants from the United Kingdom. The council delegated to a committee of four the task of assessing the experience of every applicant, and as a result 731 overseas commonwealth applicants have been fully registered. Of these, 250 qualified in Australia, 213 in South Africa, 101 in India, 69 in New Zealand, 31 in Canada, 26 in Pakistan, 19 in Ceylon, and 22 in other parts of the commonwealth. In addition, two practitioners holding recognized degrees granted in Burma have been fully registered in the foreign list.

During the same period provisional registrations were granted to 74 commonwealth practitioners, 20 of whom subsequently obtained full registration by service in the hospitals in this country; while temporary registration under section 8 of the Medical Practitioners' and Pharmacists' Act of 1947 was granted to 456 practitioners from commonwealth or foreign countries, not eligible for full or provisional registration, who were thus enabled to take up postgraduate employment in our hospitals. Most of the latter group had qualified in foreign countries, including 144 in Europe, 42 in the United States, and 23 in Egypt. Most of the overseas applicants for temporary, provisional, or full registration came for postgraduate study.

House of Commons.—Question time in Parliament often produces information of interest to physicians. On May 28, Dr. A. D. D. Broughton (Labor) discussed the shortage of residents in hospitals, particularly in the smaller ones. The main factor, he thought, was that those seeking hospital appointments preferred the larger hospitals because there they gained a wider clinical experience; another factor was that in the larger hospitals they worked as members of a team. The second choice of applicants was for the most pleasant parts of the country, such as seaside resorts. Applicants appeared to desire either a rich experience or a good holiday. This is natural since the salary is the same in all hospitals. The salary itself was an important factor, for junior appointments in hospitals were less profitable than national service in the Royal Army Medical Corps and in strong contrast with assistantship in general practice.

Dr. Broughton suggested that the recent substantial increase in the number of actions for negligence brought against junior house staff members was deterring recently qualified men and women from undertaking duties that exposed them to the danger of such charges. He wondered whether the minister would consider allowing beds to be used for patients under the care of the general practitioners. The parliamentary secretary replied that various methods had been tried in the past two years and some progress had been made, but the causes were deep-rooted and not capable of immediate solution. The two main features were supply and demand on the one hand and fair distribution of the available staff on the other. The supply of junior hospital staff fell short of the maximum establishment by less than 10%. The check on establishment had meant that, while the teaching and large hospitals had no difficulty in getting staff members, there was only a trickle to the more needy and in some ways less attractive hospitals. The priority needs of the small hospitals, it was felt, should come first, and this policy had already brought results.

The most difficult problem was in distribution, and it was particularly felt in those hospitals dealing with a narrow range of work. The cause was not any decrease in supply, but a substantial increase in demand, often caused by the upgrading of the smaller local hospitals with additional specialties. From the record of claims in the ministry, they had no evidence that claims for damages arose more particularly in respect of the smaller hospital than elsewhere. It was not practicable to increase the number of qualified physicians. About 2,000 were qualified each year. The number of probable vacancies in "career" posts appeared to be fairly well balanced in relation to intake; this, a little while ago, was a source of great concern. They could not reduce the number of physicians drafted into the R. A. M. C. Apart from the undesirability of treating physicians exceptionally, the services could not do without them. The most hopeful lines were to encourage general practitioners to work in hospitals and to encourage those returning from national service to enter the hospitals for a period rather than go into general practice immediately. The additional payment of $140 a year for internships that were difficult to fill had not been found an efficacious method as it tended to "blacklist" a hospital. The ministry looked with distaste on the idea of incentive pay for what should be a comparable job and also on any suggestion that posts should be graded above their true worth.

Middle-Aged Man's Mortality.—At the annual meeting of the British Medical Association Dr. J. N. Morris said that coronary thrombosis is now the most difficult problem facing preventive medicine. In the past 30 years mortality in females in Britain has fallen by about one-third, but in males by scarcely one-seventh. Coronary thrombosis, cancer of the lung, and duodenal ulcer are the diseases of modern civilization. A man's chances during his middle age of suffering from coronary heart disease are about 9%, from cancer of the lung 3%, and from duodenal ulcer about 4%. The vulnerability of the middle-aged man to these diseases—about 30% of 35-year-old men now die before they reach 65 compared with about 20% of women in the same age group—is changing the population of old people. In the last 25 years in Britain the number of persons over 70 increased from 1,500,000 to 3 million, but of the extra 1,500,000, one million are women. Elderly women living alone will increasingly be the social problem of the future. Coronary thrombosis and cancer of the lung, which women seem to escape, are diseases of middle-aged men. Epidemiology helped us to understand the cause of disease and often factors that might protect against disease. Thus it was found that physically active persons, such as bus conductors, had only half the mortality from heart disease of their less active counterparts, such as drivers or telephone operators. Middle-aged married women are usually more active physically than their husbands who do sedentary work. The mortality from respiratory disease is twice as high in the big cities as in the country, suggesting that some factor in city life might be the cause.

Prevention of Poliomyelitis.—The National Fund for Poliomyelitis Research has issued a leaflet, approved by the Ministry of Health, advising parents and their children to take the follow-

ing precautions if poliomyelitis appears in their district. "Do not share a towel, toothbrush, or nailbrush with others; put soiled handkerchiefs in water until they can be boiled; wash the hands thoroughly before eating and handling food, and after using the lavatory; keep fingernails short and clean. In cases of close contact with a new case of poliomyelitis keep at arm's length from other people for three weeks, and if possible sleep alone and in a separate room. Avoid crowds and unnecessary travel, and live in the fresh air as much as possible. Children should not play with those of other families and contacts should avoid swimming and paddling pools and crowds." Poliomyelitis is commonest in the summer and this time of the year has been chosen to launch a new effort to educate the public in the prevention of the disease. The campaign has been supported by Lord Webb Johnson, former president of the Royal College of Surgeons, the Medical Research Council, and Marlene Dietrich, who is now in London and has done much voluntary work in the fight against poliomyelitis in the United States.

Television Advertising.—In the debate in committee on the television bill in the House of Commons on May 31, Dr. Edith Summerskill (Labor) moved an amendment to prohibit the advertisement of articles recommended as medicaments. She said the purpose was to protect a small section of the community against the glib patter of the salesmen who represented the drug firms. An unscrupulous advertiser might play on their fears with some worthless preparation. Dr. Barnet Stross (Labor) said that the societies and associations in the medical profession would soon protest if physicians found their time was being wasted in having to explain to patients that these preparations were not so good as they were said to be or that physicians could not prescribe them. Mr. L. D. Gammans (assistant postmaster-general) said that all would agree with the spirit behind the amendment, but the authority already had sufficient powers. The standards laid down by the advertising bodies were rigorous, and the advertising interests had volunteered to set up an advisory committee. The British Medical Association had volunteered to nominate representatives to sit on the committee. This method would provide an effective safeguard against abuse. The amendment was withdrawn.

No Free Medicines for Private Patients.—At present all private patients must pay for their medicines and medical or surgical appliances; they cannot get them free as can patients on the National Health Service, although they pay equally through national insurance. The British Medical Association and the Fellowship of Freedom for Medicine, of which Lord Horder is chairman, urged that private patients be allowed medicines on the same terms as National Health Service patients. The Central Health Service Council's committee on general practice said that physicians who wanted free medicines for their private patients were unwilling to submit to conditions or enter into any contract with the Ministry of Health. The committee refused to recommend that physicians be allowed to use Health Service prescription forms for their private patients.

Cost of Training Students.—The Minister of Education stated that the number of students taking medical courses in the current academic year with grants from the department was 1,948, of whom 1,121 held state scholarships and 827 held awards under the further education and training scheme. The cost in fees and maintenance for the year is about $1,607,200. In addition, the department admitted for grant the expenditure of local education authorities on making awards to students taking medical courses; but the returns of the authorities did not enable the minister to isolate this expenditure from other expeditures on awards.

Single Prescription Costs $368.—A prescription for which a National Health Service patient paid 14 cents cost the Health Service $368. It was for an American product prescribed by a London physician for a skin condition. The cost of the drug was $214 and the difference between this and $368 was air transport, insurance, and customs charges. The executive council of the National Health Service passed the account to the Ministry of Health, which gave its approval for payment and stated that no action could be taken against the physician.

Determination of Sex.—Davidson and Smith of London have observed a morphological difference between the polymorphonuclear neutrophil in the human male and female (*Brit. M. J.* 2:6, 1954). They claim that if normal blood films are stained by the Jenner-Giemsa method the neutrophil of the female has a drumstick-like appendage in the nucleus that is absent in the neutrophil of the male. This "drumstick," which is visible when magnified 90 times, is independent of age, being present in the blood films of female octogenarians. This method of sex differentiation may be of medicolegal interest.

MEXICO

Surgical Complications in Children with Ascariasis.—Ascariasis is an important problem in Mexico, because in some areas 40% of the children are infested. Nevertheless, the abdominal complications that require intervention are rare in children. According to Drs. J. A. de la Torre and L. Arredondo (*Bol. méd. d. Hosp. inf.* **11**:153, 1954), at the Hospital Infantil de México 13 patients with complications have been found in the last 10 years. Nine of these were mechanical obstructions due to balling up of the parasites, two were volvulus, one was an intestinal perforation, and one was hepatic ascariasis. The age of the patients ranged from 19 months to 13 years. Four of the obstructions were in the ileum, three were in the jejunum and ileum, and two were in the jejunum. Between 100 and 600 parasites were found in these obstructions. The patients complained of abdominal pain, vomiting, constipation, and the presence of a tumor. Ascarides were found in the vomitus in five of the children. An abdominal mass was found in six and muscular rigidity in four. Of seven who had a complete blood cell count two showed eosinophilia; in the rest there was a leukocytosis. Roentgenograms were of no aid in the diagnosis. The treatment consisted of ileostomy in four patients, removal of the parasitic mass in two, and intestinal resection in the other three. This resection was necessary due to the presence of irreversible circulatory alterations of the intestinal loop involved. One patient died, even though his occlusive syndrome was present for only two days. He had zones of intestinal necrosis that required wide resection. The patients with volvulus had symptoms similar to those observed in the patients with obstruction, and one patient had bloody stools and signs of peritonitis. An intestinal resection was performed on both patients and excellent results were obtained. The patient with intestinal perforation had a hole 2 mm. in diameter 10 cm. from the ileocecal valve. Ascarides were found free in the abdominal cavity and several others were still in the intestine. One child had empyema of the right pleural cavity and a hepatic abscess. The autopsy showed hepatic ascariasis with numerous hepatic abscesses that caused peritonitis and empyema.

PERU

Cytotoxic Antireticular Serum and Pulmonary Tuberculosis.—Dr. Arquimedes Ramos Díaz of Callao has studied the stimulating effect on the reticuloendothelial system of cytotoxic antireticular serum in the treatment of pulmonary tuberculosis (*Revista Médica del Hospital Obrero* [July-Dec.] 1953). His series consisted of 50 patients, 18 to 67 years of age, all having active pulmonary tuberculosis caused by organisms strongly resistant to streptomycin, *p*-aminosalicylic acid, and isoniazid. The serum was given every 30 days subcutaneously in doses of 50 to 100 mg. in 1 cc. of isotonic sodium chloride solution. The maximum treatment consisted of eight and the minimum of four doses. Despite the resistance of the organisms all the patients were treated at the same time with 1 gm. of streptomycin every 48 hours, 5 mg. of isoniazid per kilogram of body weight, and 5 gm. of *p*-aminosalicylic acid daily.

Within the first week of the treatment, a marked improvement was noted in most patients. All of them, even those who were very ill, gained weight, and their appetites improved. The cough and the other clinical signs diminished and finally disappeared in almost all the patients, the recovery requiring varying lengths

of time. Radiographically, the exudative and nodular lesions disappeared or left small, fibrous scars. The cavities diminished greatly, but they did not heal completely, so that no evidence was obtained of a final solid cicatrization. For this reason the treatment should be surgical, but treatment with the serum favors the success of the operation. The fibrous lesions retrogressed and became stable. In most of the patients the number of bacilli in the sputum diminished rapidly. In some, the sputum became free of bacilli within 15 days from the beginning of the treatment. In all patients the sputum was free of bacilli on completion of the treatment. All the sputum specimens contained immature cells that the author believed to be phagocytic. The albumin-globulin ratio returned to normal in almost all the patients. In every patient there was an increase in the serum albumin level, despite the belief of some observers that the cytotoxic antireticular serum causes an increase in the serum globulin level.

Chlorpromazine in Mental Diseases.—Several investigators here are studying the healing effect of the sleep therapy produced by chlorpromazine (10-[γ-dimethylaminopropyl]-2-chloropenothiazine hydrochloride) on patients with mental diseases. At a meeting of the Neuropsychiatry Society, Drs. Saavedra and Trelles reported their results. They modified the method used by Delay, Deniker, and Hore in that besides the chlorpromazine they used barbiturates. Treating a series of 20 patients, they gave daily doses of 50 to 125 mg. of chlorpromazine, half by mouth and half intramuscularly. They also gave 0.4 to 0.8 gm. of phenobarbital or amobarbital and, to some patients, chloral hydrate and bromides. In 14 patients prompt diminution or disappearance of the agitation and anxiety were observed. The patients became tranquil and went into a light sleep. The remaining six patients had hallucinations and delirium. The early somatic effects were: marked drop of the arterial pressure, tachycardia, hyperorexia, polyuria, and constipation. The therapeutic results were poor in four patients with schizophrenia, one with anxiety neurosis, one with idiopathic epilepsy, and one with a thalamic syndrome; satisfactory in one patient with agitated melancholia and one with manic agitation; and very good in four patients with symptomatic psychosis, one with alcoholic hallucinosis, and one with an anxiety syndrome. In three patients with psychomotor epilepsy the improvement was only temporary. This therapy offers great possibilities not only because of its curative value but also because of its soothing effects that prepare the patient to accept other means of treatment.

Assembly Hall for Psychiatry.—The Mental Diseases Hospital of Lima has recently added a new assembly hall for the department of psychiatry. The dedication was presided over by Dr. Mariano Iberico. The new building is fitted with the latest equipment.

TURKEY

Effects of Antibiotics on Cutaneous Tuberculosis.—In the *Journal of Health*, periodical of the Ministry of Health and Social Assistance, Dr. Kemal Arican and Dr. K. Çagatay reported on the results of a three year experiment with antibiotics. Of 407 patients, 330 were given ambulant and 77 hospital treatment; 174 patients had colliquative tuberculosis, 115 erythema nodosum, 69 lupus vulgaris, 18 lupus erythematosus, 16 tuberculous papulonecrosis, 8 tuberculosis induration, 5 tuberculosis verrucosa cutis, 1 sarcoidosis of the skin, and 1 lichen scrofulosus. In all these patients, including those with acute, diffuse, and vascular lesions, marked improvement was observed within a short time with streptomycin therapy, but the effect of treatment was negligible in patients with fibrous, sclerotic, elephantiasic or verrucous lesions. The results were good in lupus vulgaris but were negligible in lipomas, lichen scrofulosus, and tuberculoid lesions. Only one patient had slight side-effects in the form of nausea and vertigo. Adult patients were given 1 gm. of streptomycin intramuscularly every day. Children were at first given 0.5 gm. twice daily. Marked improvement was observed in patients with colliquative tuberculosis or gum tuberculosis. One patient who had received 20 gm. of streptomycin had a recurrence after a year, and the therapy was repeated. Excellent results were obtained with a combination of streptomycin and from 10 to 20 gm. of *p*-aminosalicylic acid (PAS) daily. Some patients tolerated 300 to 430 gm. When gastrointestinal disturbances occurred, the amount was reduced. A combination of streptomycin and 3 or 4 mg. of isoniazid per kilogram of body weight was used with good results; no intolerance was observed. Streptomycin or combined therapies were most effective when patients who had lupus vulgaris or tuberculosis verrucosa cutis were previously given diathermy. Streptomycin or combined therapy had no effect on lupus erythematosus and in some patients resulted in diffusion of lesions. One patient who had disseminated lupus erythematosus was given cortisone; excellent results were obtained, but after two months there was recurrence, and this time there were lesions and arthritic pain in the left elbow.

Filariasis.—Before and during World War I, isolated cases of filariasis were occasionally seen in Istanbul. The disease had been contracted in Yemen, Saudi-Arabia, Iraq, or Egypt. For more than three decades physicians and medical students have had no opportunity of observing the clinical manifestations of filariasis at first hand. Recently a private was admitted to Istanbul Haidar Pasha Military Hospital with a swollen, painful leg. Laboratory examination revealed the presence of Wuchereria bancrofti. The patient had come from the Mediterranean province of Antalya, where he had been inducted into the army. On receiving this report, the Ministry of Health and Social Assistance appointed Professor Akalin of the Ankara School of Hygiene to investigate the area of origin. His team consisted of a microbiologist, an epidemiologist, and two laboratory technicians. A systematic search in the town and rural communities of its environs revealed several men and women with swollen limbs. Examination of the blood of a 14-year-old boy showed great numbers of W. bancrofti, although clinical manifestations were not yet apparent. As the area is in one of the malarial campaign zones and chlorophenothane (DDT) had been in use there for five years, the careful search for mosquitoes proved unsuccessful. Further investigation revealed that all affected persons were members of the personnel of sailing vessels carrying timber to Egypt. The ministry of health has commissioned all health departments of the Mediterranean provinces to make further investigations, and circulars calling attention to the occurrence have been issued to all other health departments.

Narcotic Law Enforcement.—Since the promulgation of the new narcotic law last September, one sentence of death, a number of life imprisonments, and several long prison terms have been pronounced under this law. Three men and a woman are currently under sentence of death. Because of the vigilance of the police it has become increasingly difficult to buy narcotics ($35 is being asked for 1 gm. of heroin) and many of the drug addicts have turned to theft. The 20,000 drug addicts are undergoing severe crises. They are found in certain coffee houses and other places and are daily brought into court. Istanbul-Bakirköy Mental Hospital can only accommodate 70 such patients. Most addicts are unemployed; almost half are tuberculous men between 20 and 30 years of age, but a few are society women. Although persons visiting prisoners are carefully searched, they sometimes succeed in smuggling narcotics to inmates. The black market price of narcotics has induced a number of addicts to turn informer for a reward. The establishment of a reformatory for incorrigible drug addicts is being considered.

New Minister of Health.—The new National Assembly elected in May has 71 members who are physicians. Prime Minister Menderes has three physicians in his 10-member cabinet. Dr. Behcet Uz, who was Minister of Health and Social Assistance, 1946 to 1948, has been reappointed to that office. He is a pediatrician, a native of Izmir, and former mayor of that city. He was instrumental in the establishment of the new, 250 bed Izmir Children's Hospital and the Izmir Ege College. Foremost on Dr. Uz's program are increases in the numbers of hospital and maternity beds, health centers in rural communities, and adequately trained medical, hospital, and related personnel and the introduction of a bill for the establishment of national health insurance.

CORRESPONDENCE

NEGATIVE CANCER THERAPY DATA

To the Editor:—In April, 1953, a supplement to volume 13 of *Cancer Research* was published in order to present a backlog of negative data on compounds tested in experimental cancer chemotherapy programs. A second supplement is planned for publication early in 1955 that will present additional negative data. It is planned also to include data from clinical cancer chemotherapy programs. The next supplement will be made possible by grant C-2198 from the National Cancer Institute of the U. S. Public Health Service.

This announcement is to invite the submission of data from experimental studies for inclusion in the supplement. Material should be submitted in the form that was presented in the initial invitation for data (*Cancer Res.* **12**:614, 1952) and subsequently used in the first supplement. Those planning to submit data should note the type of information requested: a brief account of the experimental procedure is required, including the method of evaluation and, when possible, examples of typical results obtained with a few compounds that have shown antitumor effects. The clinical data should take the form of the table used in the article by Steinfeld, White, Petrakis, and Shimkin (*Cancer Res.* **14**:315, 1954). The types of clinical measurements used in evaluation of the effects of drugs on disease should be indicated. The material should be provided with compounds listed alphabetically and with empirical formulas, in legible form. Structural formulas should be provided for any compound that cannot be unequivocally named. If desired, the compounds could be listed in groups according to chemical types. The material should be submitted to any of the editors listed below by Oct. 15. The editorial committee will reserve the right to omit any data that provide inadequate information. The editors include:

Dr. Ralph Barclay, Division of Experimental Chemotherapy, Sloan-Kettering Institute for Cancer Research, 410 E. 68th St., New York 21.

Dr. Arthur Furst, Department of Pharmacology and Therapeutics, Stanford University School of Medicine, San Francisco 15.

Dr. Alfred Gellhorn, Columbia University College of Physicians and Surgeons, 620 W. 168th St., New York 32.

Dr. Joseph Leiter, National Cancer Institute, U. S. Public Health Service, Bethesda 14, Md.

Dr. Michael Shimkin, National Cancer Institute, U. S. Public Health Service, Bethesda 14, Md.

Dr. C. Chester Stock, Sloan-Kettering Institute for Cancer Research, 410 E. 68th St., New York 21.

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Division of Experimental Chemotherapy
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MECHANISM OF APOPLEXY

To the Editor:—The editorial "The Mechanism of Apoplexy" (*J. A. M. A.* **155**:578 [June 5] 1954) states that there is no adequate proof that the blood vessels of the human brain are capable of active constriction. On the contrary, there is a growing body of evidence that they are. This evidence can be summarized under five headings: anatomic, physiological, angiographic, neurosurgical, and experimental.

The basic anatomic consideration is the presence of smooth muscle fibers in the cerebral arteries and arterioles. Under appropriate circumstances these muscles may be expected to contract. The main physiological evidence is the inverse ratio of cerebrovascular resistance (as measured by the Schmidt-Kety method) to carbon dioxide content of the circulating blood. Angiographic evidence of active cerebral arterial spasm has been reported in the past three years. Such observations include spasm after a recently ruptured aneurysm of the circle of Willis or after an apoplectic stroke (*J. Neurosurg.* **8**:660, 1951, and **10**:404 and 634, 1953; *Neurology* **3**:495, 1953). The neurosurgical evidence of cerebral arterial spasm in human beings has been gathered primarily from the subarachnoid (terminal) portion of the internal carotid artery. The spasm has resulted from traction (personal observation); the application of an electric current to a nearby branch (Thomas Hoen); and the deliberate stroking of the artery to make it smaller. This contraction was needed either to receive a metal clip that previously was too small (Robert Bassett) or to provide additional room for approach to the pituitary body (Bronson Ray).

Besides these studies in human beings, there are a number of excellent reports of the production of cerebral arterial contraction in experimental animals (Villaret and Cachera; Francis Echlin; Harvey and Rasmussen; John Webster). The editorial comment on the limitations of current knowledge of the vascular physiology of the brain is sound. In our opinion, however, further advances in this field are likely to occur (*Ann. Int. Med.* **40**:49, 1954) more rapidly after the acceptance of the fact that significant cerebral arterial spasm does occur.

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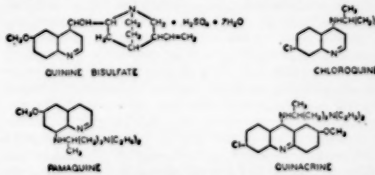
CHLOROQUINE, QUININE, AND QUINACRINE

To the Editor:—I would like to call your attention to several errors that occurred in an article entitled "Treatment of Chronic Discoid Lupus Erythematosus with Chloroquine (Aralen)" by Donald M. Pillsbury and Coleman Jacobson that appeared in The Journal (**154**:1330 [April 17] 1954), in the hope that something can be done to prevent their becoming perpetuated in the literature.

On page 1331, second paragraph, lines 8 and 9, is the following statement: ". . . (Plasmochin), which is similar to quinine in that both are substituted 8-amino quinolines." Quinine is not an 8-amino quinoline. Both quinine and pamaquine (Plasmochin) are 6-methoxyquinolines, but they differ from each other markedly in other ways. On the same page, third paragraph, first two lines, is the statement "Quinacrine, which differs from pamaquine only in the addition of a benzyl chloride group . . ." This statement is entirely incorrect and appears to arise from the authors' erroneous formulae for these preparations. The sixth paragraph in this column is badly garbled. The formula for chloroquine does not differ from that of quinacrine only in that the latter has an added benzoxymethyl group. It would be accurate to say that chloroquine differs from quinacrine in that the latter is a methoxybenzoquinoline. The second sentence in this paragraph is also incorrect. Chloroquine is not an 8-amino-



quinoline. It would be correct to say that pamaquine and chloroquine are both derivatives of quinoline, but pamaquine is a derivative of 6-methoxy-8-aminoquinoline, whereas chloroquine is derived from 7-chloro-4-aminoquinoline. The formula chart is incorrect in several respects. The accompanying figure is a corrected formula chart.

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1450 Broadway, New York 18.

AN OLD EPITAPH

To the Editor:—In some reading in connection with a book I am writing on my family lines, I happened on an old epitaph that I thought might be of some interest to the medical profession. In "Tidewater Virginia," by Paul Wilstach (Indianapolis, Bobbs-Merrill Company, Inc., 1929, p. 60), there is the following paragraph about a tombstone bearing a date two years earlier than the landing of the Mayflower:

"There was one other shadowy figure on the shores of the Potomac who was forgotten until Moncure D. Conway found, on Potomac Run, a tombstone on which was this inscription:

HERE LIES INTERED
THE BODY OF EDMOND
HELDER PRECTIONER IN
PHYSICK AND CHYRURGE
RY. BORN IN BEDFORDE
SHIRE OBIIT MARCH 11
1618. S ATATIS SUA Y6

"He was prompted to his search by a rumor which persisted during the middle of the last century that 'one of the Pall Bears of William Shakespeare' was buried in Fredericksburg. He found nothing to sustain that rumor, but in a wider flung search he did find the new world's oldest English epitaph."

Thus our oldest gravestone was that of a physician.

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BUREAU OF LEGAL MEDICINE AND LEGISLATION

MEDICOLEGAL ABSTRACTS

Workmen's Compensation Acts: Employee's Suit for Malpractice by Physician.—This was an action against the defendant chiropractors and the defendant Shane Diagnostic Foundation, a partnership engaged in the practice of chiropractic, for damages alleged to have been caused by their malpractice. From a judgment for the plaintiff, the defendants appealed to the district court of appeals (Duprey v. Shane, et al., 238 P. [2d] 1071 [California, 1951]; *J. A. M. A.* **150:**1142 [Nov. 15] 1952) and then to the Supreme Court of California.

The plaintiff was a practical nurse employed by the Shane Diagnostic Foundation. While she was giving therapy to a patient in the course and scope of her duties, the patient started to roll off the treatment table. The plaintiff, who was standing on the opposite side of the table, grabbed the patient in order to break the fall and in doing so was pulled across the table with a "terrific yank" to her shoulder. No injury to her neck was received at that time, but a short time after the accident her head began to ache and she began to suffer pain in her right arm and shoulder. The accident happened on Dec. 8, and during the next few days the plaintiff received a number of "Palmer Adjustments" (application of pressure to the neck while the patient is reclining) and "quick cervicals" (a twisting and jerking of the head in the effort to try to snap in anything out of place) from Dr. Shane and another chiropractor employed by the foundation. During this period no x-ray or fluoroscopic examination was made. On Dec. 15 the plaintiff's condition had become worse, and the pain became so severe that she consulted a physician and surgeon who was a doctor of medicine. He took roentgenograms that disclosed a partial dislocation of the fourth cervical vertebra. The plaintiff was subsequently treated by other physicians, and the court held that the evidence was sufficient to authorize the jury to find that there was no causal connection between the occupational injury and the subsequent dislocation from which she suffered. In other words, the plaintiff suffered damages as a result of the chiropractic manipulation. Accordingly, after being granted an award by the Industrial Accident Commission for the injury sustained in the course of her employment, the plaintiff filed this action for damages resulting from such manipulation.

The basic arguments of the defendants were that the commission had exclusive jurisdiction over all the injuries incurred by the plaintiff and that its granting of a compensation award is *res judicata* of the issues in this action. The question involved can be stated as follows: Where an employee of a physician is injured in the course and scope of the employment, and the insured employer treats the industrial injury and does so negligently, proximately causing a new and further injury and disability, may the employee sue the employer-physician for malpractice, or has the commission exclusive jurisdiction?

So far as the original injury of Dec. 8 is concerned, the employer being insured, the remedy before the commission is "the exclusive remedy against the employer for the injury." Furthermore, when a person is injured by a tortious act and this injury is aggravated by the negligence of the attending physician, such aggravation of the injury is within the scope of the risk created by the original tortious act. Thus, where an employee is injured in an industrial accident, and this original injury is aggravated by the negligence of the attending physician, and the employee seeks recovery for the original injury and for the aggravation from his employer or from his insurance carrier, the Industrial Accident Commission had exclusive jurisdiction to determine this claim against the employer or his carrier. When an employee is injured in an industrial accident and the attending physician is negligent and causes a new injury, however, the employee may not only sue the employer before the commission but also sue the physician for malpractice, and the commission has no jurisdiction of the action against the physician. This is on the theory that the physician in such cases is a third person—a person other than the employer. The defendants claim, however, that the rule that the employee injured in an industrial accident can sue the attending physician for malpractice only applies when the physician is actually a third person and has no application where the attending physician and the employer are one and the same person.

This fact, said the Supreme Court, should not affect the legal rights of the employee. There seems to be no logical reason why the employer-physician, when he undertakes to treat the industrial injury, should not be responsible in a civil action for his negligent acts in treating that injury. Once it is established that an action before the commission for the industrial injury is no bar to an action against an insurance physician for malpractice, it would seem to follow that the employee does not lose his right to such an action simply because the physician who treats the injury happens to be the employer. In such event, the employer-physician is a "person other than the employer" within the meaning of the Labor Code. In treating the plaintiff's injury, defendant Shane did not do so because of the employer-employee relationship; he did so as an attending physician, and his relationship to the plaintiff was that of physician and patient.

We therefore conclude, said the Supreme Court, that an employee injured in an industrial accident may sue the attending physician for malpractice if the original injury is aggravated as a result of the physician's negligence, and that such right exists even though the attending physician is the employer. Accordingly the judgment in favor of the plaintiff was affirmed. *Duprey v. Shane, 249 P. (2d) 8 (California, 1952).*

Expert Witnesses: Mere Licensure Not Sufficient Qualification.—This was an action for damages against the defendant physician for alleged negligent treatment of a broken leg. From a judgment in favor of the defendant in the trial court the plaintiff appealed to the superior court of New Jersey, appellate division.

The defendant physician was licensed as a medical doctor in New Jersey and treated the plaintiff for a fractured left leg, but whether the treatment was administered in the capacity of a general practitioner or a specialist is not clear. When a physician accepts a patient, said the court, he is required to have and to exercise, in diagnosis and treatment, the skill normal to the average member of the profession. If he is a general practitioner

he must use in the care of his patient the skill normal to the average member of his profession practicing as such. On the other hand, one who holds himself out as a specialist must employ not merely the skill of a general practitioner, but also that special degree of skill normally possessed by the average physician who devotes special study and attention to the particular organ, disease, or injury involved, having regard to the present state of scientific knowledge. Continuing, the court said that when a physician is charged with negligence in the diagnosis or treatment of a patient's condition two elements of proof are essential: first, the establishment of standards that are generally recognized and accepted by the branch of the profession to which he belongs as the customary and proper methods of diagnosis or treatment of the physical or mental condition concerned in the inquiry; second, a departure from such standards under circumstances justifying the conclusion of want of the requisite degree of due care. What constitutes proper treatment is a medical question to be presented by experts, and neither the courts nor jurors can be permitted to say or to speculate as to what technique should be utilized for a certain disease or injury or how a specific surgical operation should be conducted. If no standard is established through medical witnesses, then the jury has no standard by which to gauge the basic issue of fault of the physician. The need for expert testimony does not mean that the witness must be a specialist, however, although the fact that he is not may be taken into consideration in weighing his testimony.

The plaintiff offered the testimony of a New York physician as an expert witness, but the trial court declared him not qualified and declined to allow him to testify. On appeal it was urged that this action of the trial court was erroneous. Primarily it was argued that when a person meets the statutorily prescribed educational standards of a state and is licensed to practice medicine by the proper authorities, as a matter of law he automatically becomes qualified and competent to testify in any field of medicine or surgery, and the weight of his testimony is for the jury to determine. Secondly, it was asserted that if the trial court had the discretionary power to pass on the qualifications of the witness, consideration of all the facts demonstrates that he was guilty of a mistaken use of that discretion.

There is no case in New Jersey, said the court, to the effect that mere possession of a license to practice medicine, without more, renders the holder competent to express an opinion in an action based on damage resulting from alleged negligent care or treatment of a patient by a physician. The reason seems obvious. In malpractice cases proof of the standards recognized and applied by the medical profession in the situation under investigation must be introduced, as well as proof of such a deviation therefrom as would warrant a determination of culpability. This evidence can come only from one who, through experience or study or both, knows the standards. Therefore, a showing of such knowledge is a prerequisite to the competency of the proffered medical witness. No reference has been made to any canon of ethics in New Jersey that proscribes the giving of testimony by one physician against another. However mindful we are of the problem of proof, the proposed rule of evidence that would qualify as an expert witness in a medical malpractice case any holder of a license to practice medicine, without further proof of his knowledge of the particular subject and of the standard of conduct by which his fellow practitioner's liability should be tested, would not represent a just appraisal of the interests involved.

In our state, the court continued, the determination of the issue of the qualifications of a witness to testify as an expert has always rested in the discretion of the trial court, and his ruling with respect thereto will not be disturbed on appeal unless erroneous as a matter of law or so clearly the result of an unreasonable evaluation of the facts as to constitute a mistaken use of discretion. In considering the competency of a proffered expert medical witness, when there is any reasonable evidence of qualification, in addition to the license, he should be permitted to testify. Cross-examination will expose any weaknesses in or limitations on his knowledge and experience. And then the weight to be accorded his testimony may be left where it has rested traditionally, namely with the jury.

The plaintiff's tendered witness was 82 years of age at the time of the trial and had been licensed to practice in New York for many years. He graduated from Tulane University with a degree in 1890. While at the university he attended the Charity Hospital and saw a number of compound comminuted fractures of the leg. He observed the manner in which they were treated and rendered some assistance to the treating physicians. Upon graduation he went to Australia for a time and then went to England, where he remained three years studying surgery. While there, among other things, he studied under "one of the biggest orthopedic surgeons in the world." He underwent successfully an examination before the Royal College of Surgeons of England and was given a diploma as a member of the Royal College. Then he studied pathology and urology in Berlin for six months and advanced surgical obstetrics in Vienna for a like additional period. He returned to New York City about 1905 and became the first assistant in the laboratory of the Post-Graduate Hospital. In the ensuing years he was assistant gynecologist at Mount Sinai Hospital and worked in the same field, that is, gynecology and surgery relating thereto, at the Sydenham Hospital and as associate gynecologist at St. Mark's Hospital, all in the same city. He was also visiting surgeon to the Maternity Hospital in New York City and consulting surgeon to the Home for the Aged and Infirm in Yonkers, New York, and to the Institution for Adolescent Delinquents in Pleasantville, New York. The memory of the witness, perhaps because of his age, was not as specific as it might have been with respect to the dates and periods of these various connections.

The physician continued to practice in New York City until about "1928, 1929 or 1930," when he suffered a heart attack that confined him to bed for three months. This brought about a restriction of his activities. He resigned from the New York Academy of Medicine, of which he had been a fellow, and from membership in the American Medical Association, which he had held for 30 years. Exactly what the nature of his practice was after the illness is not clear from the evidence. He said he was not "physically able to go on with operative work and all that. So now, of course, I am still practicing medicine but mostly office work, because I don't think it would be fair for me to do operative work at my age." Prior to the trial he had not performed an operation for over 20 years. He had visited various hospitals in New York City about 10 or 15 times a year to observe operations, although no such visits had been made for about a year. He kept abreast of medical and surgical progress by reading. He had a substantial medical library of his own and studied the various works "quite assiduously"; in addition, he studied the medical journals, such as the *Journal of the American Association of Military Surgeons* and a weekly publication known as *New York Medicine;* and he frequently visits the library of the Academy of Medicine in New York City for purposes of study. On cross-examination it appeared that while he had neither treated nor observed the treatment of fractures in 1946, he knew what the method of treatment was and he knew what was being done in hospitals in 1946 for fractures. This knowledge came from his reading and study of books and medical journals. On being asked, he furnished the names of the authorities whose books he had read on the subject. These statements stand unqualified and uncontradicted.

A person, said the court, can become an expert through actual experience or study or both. The plaintiff presented a witness of substantial educational background in his profession and many years of practice. While it is true that he is not a specialist in the field of orthopedics, he asserted knowledge of the method of treatment of fractures both in hospitals and generally and supported the assertion by the specific references to which we have adverted. In refusing to allow him to testify, the trial court declared in effect that he had no qualifications that would render him competent as an expert. In the light of the evidence on the subject and the requirement of liberal appraisal thereof, the rejection of the witness was erroneous and constituted a mistaken use of discretion. The witness should have been permitted to testify, and the weight of his statements should have been left for the jury to determine.

Accordingly the judgment in favor of the defendants was reversed and a new trial ordered. *Carbone v. Warburton, 91 A. (2) 518 (New Jersey, 1953).*

MEDICAL LITERATURE ABSTRACTS

INTERNAL MEDICINE

The Serious Problem of Bronchial Cancer. C. Oberling. Presse méd. **62:**712-715 (May 5) 1954 (In French) [Paris, France].

The striking and inexorable increase in pulmonary cancer that has taken place since the close of World War I closely parallels the increase in the consumption of cigarettes during the same period. Various other factors, such as the 1918-1920 influenza epidemic, the use of tar on streets and highways, and pollution of the air by industrial gases and vapors and motor exhaust fumes have been suggested as possible causes of the increase, but the arguments advanced in their favor cannot be maintained. Inhalation of cigarette smoke carries the products of tobacco combustion from the burning center, where the temperature reaches 700 C, directly to the mucous membrane of the entire bronchial tree, on which they are deposited in the form of tar. The same effect does not result from cigar or pipe smoking, because the smoke produced by these methods is too bitter and alkaline to inhale. Numerous experiments by different workers have conclusively established the fact that tobacco tar is capable of producing cancer, though its carcinogenic properties are less than those of coal tar. Efforts have been made to identify the carcinogenic substance or substances in tobacco smoke, but they are still unknown; nicotine, however, can be definitely eliminated as a causative agent. Physicians should recognize the gravity of the problem and, even if not willing to set an example by abstaining from cigarette smoking, should refrain from influencing persons about to give up the habit adversely by expressing skepticism in regard to the connection between cigarette smoking and pulmonary cancer. A fatalistic attitude leading to suggestions that persons who have been confirmed cigarette smokers for years will not be saved from cancer by giving up the habit is equally unjustified, because experiments have shown that in cases in which as many as 30 applications of cigarette tar have been given to mice without harmful effect, a 31st application has resulted in the development of cancer. The cause of cancer is always complex, and many factors may be involved, but the prime importance of excessive cigarette smoking in lung cancer is hardly open to question.

Potential Vectors and Reservoirs of Hemorrhagic Fever in Korea. R. Traub, M. Hertig, W. H. Lawrence and T. T. Harriss. Am. J. Hyg. **59:**291-305 (May) 1954 [Baltimore].

Over 2,000 cases of hemorrhagic fever were observed in United Nations troops in Korea. This disease is undoubtedly the same clinical entity encountered by the Japanese Army in Manchuria and by the Russians in Siberia and named by them, respectively, epidemic hemorrhagic fever and hemorrhagic nephrosonephritis. Both the Japanese and Russians believed the disease to be transmitted by arthropods, with field rodents as reservoirs. During investigations dealing with the epidemiology and cause of hemorrhagic fever in Korea in 1952, a survey was made of the ectoparasites of indigenous rodents trapped in three endemic areas. Data are presented indicating that trombiculid mites (chiggers), laelaptid mites, fleas, and ticks all could be regarded as potential vectors, but that chiggers alone can be correlated with the epidemiology. Potential reservoirs are more likely to be found among field rodents than among domestic rats and mice.

The place of publication of the periodicals appears in brackets preceding each abstract.

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Clinical and Experimental Studies on Antirheumatic Activity of Amidopyrine Gentisate. S. Mainoli and O. Piccinelli. Minerva med. **45:**787-791 (March 21) 1954 (In Italian) [Turin, Italy].

Pirisal is a drug obtained by the salification of gentisic acid with pyramidone, with the addition of a synthetic antihistaminic derivative of benzohydrol. Mainoli and Piccinelli studied experimentally and clinically the therapeutic activity of this preparation in healthy persons and in patients with rheumatic disease. When they administered it, partly orally and partly parenterally, to 15 persons in good health, a 50% drop in the number of eosinophils followed. Thus, a corticotropin-like action of the preparation and its activity on the hypophysis-adrenal system was confirmed. The combination of the three drugs has a synergistic action. This was confirmed when administration of each separate component of the preparation to different persons failed to produce a marked eosinopenia. Of the three, pyramidone was the most active in inducing eosinopenia. The authors used Pirisal to treat 38 persons with chronic rheumatic disease and 5 with acute rheumatic disease of joints. The first group of patients received four tablets and one vial or one suppository for a total daily dose of 1.375 gm. of amidopyrine gentisate, 0.375 gm. of pyramidone, and 0.063 gm. of the benzohydrol antihistamine derivative. The second group received eight tablets and one vial or one suppository. All the patients tolerated the drug well. Pain disappeared in at least 90% of those with rheumatic myalgia and rheumatic disease of the lumbar spine. Although the effects were poorer in patients with acute rheumatic involvement of joints, these were also improved and pain, temperature, and swelling were decreased. Functional restoration was good in 60% of the patients with chronic primary or secondary rheumatism and with rheumatic disease of the lumbar spine and effective in patients with rheumatic myalgia. It was less evident in patients with scapulohumeral periarthritis, but in these roentgenograms taken before therapy had shown advanced and already irreversible anatomic lesions. The best results were obtained in patients with uncomplicated conditions of recent onset in whom irreversible anatomic lesions were not present. The authors combined Pirisal with cortisone or corticotropin in some patients and the combination proved particularly useful. They feel that this drug should be used for treating rheumatic disease, because it is well tolerated, easy to administer, and low in cost.

Severe Reactions to Para-Aminosalicylic Acid: A Case Report and Brief Review of Literature. D. R. Korst. Ann. Int. Med. **40:**1011-1016 (May) 1954 [Lancaster, Pa.].

The increasing use of *p*-aminosalicylic acid in the chemotherapy of tuberculosis makes prompt recognition of reactions to the drug desirable. Reactions may be unusual in character, but are more generally of the acquired sensitivity type and follow a pattern that is specific to *p*-aminosalicylic acid. Patients with acquired sensitivity present a generalized systemic response with fever, rash, nausea, emesis, joint aches, muscle pain, headache, and sometimes mild paresthesias. Leukocytosis and eosinophilia are also frequently seen. The reactions subside promptly when the use of *p*-aminosalicylic acid is stopped. A milder reaction accompanied by eosinophilia can then be elicited by giving the patient a test dose of the drug. Acquired sensitivity in the author's patient, a 28-year-old white man admitted to the hospital because of uncontrolled diabetes and pulmonary tuberculosis, first appeared in the form of a dry scaly rash resembling tinea versicolor two weeks after the initiation of antituberculous treatment (streptomycin and *p*-aminosalicylic acid). The reaction was greatly intensified on the 28th day when severe generalized pruritus developed, and the rash on the upper thorax became more erythematous and macular in appearance. Muscle aching, joint pains, and an upset stomach appeared later in the day and were accompanied by chills and fever. All medication was stopped and the symptoms gradually subsided over the next 17

days, during which the patient obtained some relief from oatmeal baths and antihistamines. The white blood cell count taken at the height of the reaction showed 24,000, with 12% neutrophils, 68% large lymphocytes, 11% small lymphocytes, and 8% eosinophils. No further medication was given until the patient was symptom-free, i. e., for almost three weeks. A test dose of 4 gm. of *p*-aminosalicylic acid was then tried, and some hours later the patient complained of nausea, fever, and chills and was noted to have mild urticaria; the following day, he had a sore throat. The reaction subsided promptly thereafter. Isoniazid therapy was instituted, and streptomycin, which had been given before the reaction, was added cautiously; this treatment has been well tolerated and the patient is continuing to improve clinically. The reaction seen in this case was apparently specific for *p*-aminosalicylic acid, since the patient's history showed no known allergy and he had no reaction to other medicaments. Desensitization can usually be accomplished if the continuance of *p*-aminosalicylic acid therapy seems advisable. Cross sensitivity to salicylates, which may develop in patients with *p*-aminosalicylic acid reactions, should be checked for the future guidance of both the physician and the patient.

Two Cases of Primary Tuberculosis After Immersion in Sewage-Contaminated Water. F. J. W. Miller and J. P. Anderson. Arch. Dis. Childhood **20**:152-154 (April) 1954 [London, England].

Miller and Anderson present histories of two children, aged 4 and 2½ years, respectively, in whom a primary tuberculous infection developed after immersion in sewage-contaminated water. After swallowing contaminated water, each child had gastrointestinal symptoms that cleared after a few days. After two or three weeks of apparent good health, a febrile illness developed and gave evidence of primary tuberculous infection. The circumstantial evidence is strong enough to suppose that the bacilli were inhaled during immersion, and thereafter a primary complex was formed in the lung. The infection in the second child from standing sewage water seems to have been much heavier than in the first, producing a heavy bilateral primary infection. That the shadow in the first case cleared completely without leaving calcification or other scarring is not exceptional, as this is often observed in children undergoing tuberculin conversion. That tuberculous meningitis developed in the first child can be regarded as an unfortunate risk of primary infection, but as 85% of cases of tuberculous meningitis develop within a year of the primary infection the fact is an additional pointer to the nature of the first illness. Primary tuberculous infection is rarely thought to arise by routes other than by aerogenous spread into the lungs or ingestion of infected milk into the alimentary tract. Yet other routes of infection are possible, as demonstrated by these two cases. Although they were unable to find any record that this method of infection had previously been reported in England, they found reports of other cases of this type in the Scandinavian literature (abstracted in THE JOURNAL **137**:1633 [Aug. 28] 1948).

An Outbreak of Trichinosis in Liverpool in 1953. A. B. Semple, J. B. M. Davies, W. E. Kershaw and C. A. St. Hill. Brit. M. J. **1**:1002-1006 (May 1) 1954 [London, England].

The first of 82 cases of trichinosis detected in the outbreak described came to the attention of the health department of Liverpool when a physician notified the department on Nov. 6, 1953, of having seen a case of trichinosis. This patient was admitted to hospital, and the diagnosis was confirmed by muscle biopsy. Inquiries were made immediately in the same and other hospitals, and three further suspicious cases were found. Since it was felt that these cases might be part of a more widespread outbreak, a letter was sent to all general practitioners and consultants requesting information of any other cases. Such reports were received until the third week in November. The earliest inquiry into the source of infection suggested that sausages of a local firm were probably the cause of infection as many of the patients had eaten them raw. Further confirmation came when one of the patients who worked in the sausage factory reported that she habitually nibbled at raw sausage meat, and 12 of the patients were employees of the firm. In two instances, pork roasted at home was responsible. Women were affected more often than men (60 to 22). A detailed review of the symptoms of 82 cases revealed that edema of eyelids, headache, muscular pains, pyrexia, photophobia, and insomnia were the commonest signs and symptoms. A fatal case is recorded. Since myocarditis may develop in the second or third week of the disease, any suggestion of cardiac involvement should be treated seriously and the patient nursed in a recumbent position, as there is a possibility of sudden death. Larvae were isolated from the muscles of 16 patients. Fifty-two of the patients were followed up by health visitors four to six weeks after their illness. Only 15 of these patients reported that they fully recovered. The majority complained of tiredness and lack of energy, and 24 had not returned to work. Nine of the group had some transient breathlessness that lasted a few days, developing in every case from the third to fifth week. Trichinosis is an exhausting, debilitating disease from which recovery is very slow.

Culture of Vaccinia Virus in Explanted Fetal Bovine and Ovine Skin Tissue. H. S. Frenkel and J. G. Kapsenberg. Nederl. tijdschr. geneesk. **98**:991-996 (April 10) 1954 (In Dutch) [Amsterdam, Holland].

The culture of the virus of hoof and mouth disease in fetal bovine skin tissue induced Frenkel and van Waveren in 1938 to use this method also for the culture of vaccinia virus. After the war these studies were resumed and now Frenkel and Kapsenberg find that they are able to obtain a bacteriologically sterile vaccine against smallpox by cultivating vaccinia virus in vitro in explanted fetal bovine and ovine skin tissue in a liquid medium. Mincing the skin tissue was found to be superfluous. The titer of this virus, as determined on the chorioallantoic membrane of 12 day chicken embryos, measured 10^{-5} to 10^{-7}. So far 40 passages have been cultivated in fetal bovine skin and 5 in fetal ovine skin. After experiments on animals and revaccination of human volunteers, a number of children under 2 years of age were vaccinated successfully with virus of the 30th passage. The use of this new vaccine may possibly lead to a better understanding of the problem of postvaccinal encephalitis.

Prolonged Anuria: Successful Management by Continuous Infusion into the Inferior Vena Cava. C. S. Russell, C. J. Dewhurst and J. C. Brace. Lancet **1**:902-905 (May 1) 1954 [London, England].

The case described is that of a 31-year-old woman, para 3, who had a septic abortion. There followed complete anuria lasting 11 days and partial anuria lasting a further 10 days. Intragastric tube feeding occasioned much vomiting and failed to initiate any improvement. In order to provide the patient with a diet of 1,600 calories and not over 1 liter of fluid daily, a 40% dextrose solution was needed, and since this could not be infused into a peripheral vein without causing thrombosis, a cardiac catheter was introduced into the superior vena cava on the sixth postoperative day and intravenous drip maintained constantly for four days. At the end of that time, the catheter was transferred to the inferior vena cava because of thrombophlebitis with pain, edema, and reddening of the arm. Continuous infusion was maintained in this way, with no complications, for 17 consecutive days, during which time the patient's condition improved. Recovery was rapid and uneventful. The authors point out that the techniques of inferior and superior vena cava infusion are neither dangerous nor difficult. The former method is preferable. Constant laboratory surveillance of electrolyte and fluid balance and careful management of the technical details of intravenous infusion are essential.

Addison's Disease Associated with Thyroid Insufficiency and Atrophy (Schmidt's Syndrome). J. M. B. Bloodworth Jr., W. M. Kirkendall and T. L. Carr. J. Clin. Endocrinol. **14**:540-553 (May) 1954 [Springfield, Ill.].

Thirty-five cases of Addison's disease are reviewed. The presence of pituitary insufficiency was ruled out by clinical and laboratory evaluation and autopsy findings. Twelve postmortem examinations were made. Four autopsy cases showed absence or almost complete destruction of the thyroid gland and four others showed extensive destruction by lymphocytic infiltration, fibrosis, and atrophy of thyroid follicles. Nine of the 35 patients

were clinically hypothyroid, and many of the others showed symptoms that could be attributed to hypothyroidism; 7 showed definite laboratory evidence of hypothyroidism. In two patients with clinical evidence of myxedema, tests showed normal thyroid function, but, in four patients whose tests showed abnormal thyroid function, there was no clinical evidence of hypothyroidism. Thus in 13 cases there was either clinical or laboratory evidence of hypothyroidism, and in almost all there were some clinical, laboratory, or anatomic thyroid abnormalities. In histological studies of the thyroid gland of patients with Addison's disease, the outstanding change is lymphoid infiltration. It has been conjectured that the infiltration is secondary to degeneration of the gland. However, adrenocortical extracts can cause lysis of lymphocytes and tend to prevent growth of lymphoid tissue. Since absence of these hormones, as in Addison's disease, causes hypertrophy of lymphoid tissue, it is possible that the latter state may result in excessive lymphoid proliferation and secondary destruction of the thyroid follicles. Such a theory would explain myxedema occurring some time after the onset of Addison's disease but not cases with glandular atrophy occurring in the opposite sequence. Another remote possibility for the association of atrophy of these two glands is the accumulation of some unknown antibody in the thyroid as a result of loss of the protective effect of adrenocortical hormones against an unknown antigen-antibody reaction.

Giant Follicle Hyperplasia: A Study of Its Incidence, Histopathologic Variability, and the Frequency of Sarcoma and Secondary Hypersplenic Complications. T. S. Evans and C. A. Doan. Ann. Int. Med. **40**:851-880 (May) 1954 [Lancaster, Pa.].

Giant lymph follicle hyperplasia, also known as follicular lymphoblastoma, is a chronic splenolymphatic disease sometimes complicated by sarcomatous changes. Its course, when uncomplicated, may be prolonged, and the ease with which the benign form of follicular hyperplasia in the lymph nodes and spleen can be controlled by x-ray or radioactive phosphorus therapy justifies an optimistic, though guarded, prognosis to patients with this disease. Indications of sarcomatous change, of course, alter the prognosis and necessitate a reappraisal of the therapeutic possibilities. Patients with follicular hyperplasia are apparently peculiarly susceptible to the development of secondary hypersplenic cytopenic episodes; splenomegaly was found in 11 of 16 patients personally studied by the authors in work being carried on at the lymphoma clinic at the Ohio State University Health Center and in the hematology clinics at the Yale University Medical Center. Splenectomy was required by eight of these patients for the relief of more or less acute episodes of cytopenia. The complicating syndromes—acute hemolytic anemia (3), thrombocytopenic purpura (2), a combination of profound neutropenic leukopenia and thrombocytopenia (1), and peripheral pancytopenia involving all of the circulating formed elements of the blood (2)—were promptly reversed by surgical removal of abnormal splenic tissue. Recurrence of the cytopenic syndrome suggests the presence of an accessory spleen, removal of which will again be followed by a remission. Reticuloendothelial cell hyperplasia with specific hyperphagocytosis was histologically demonstrated in the spleens removed from these eight patients. Hyperplasia of the reticuloendothelial cells seems to underlie and to be at least partly responsible for the development of the abnormally enlarged germinal follicular centers found in follicular lymphoblastoma, but the cells within the enlarged follicles may vary in type from patient to patient, and even in the same patient from time to time. Thus the predominant cells may be either large fixed reticulum cells without pronounced phagocytic capacities, or free mononuclear phagocytes, or cells interpreted as germinal center lymphoblasts, with or without sarcoma characteristics. A fairly accurate prediction of the clinical course and individual prognosis may be based on the identification of these several morphologically and functionally (supravital technique) differing cell types. The cause, or causes, of giant lymph follicle hyperplasia is entirely unknown at present, but the relatively benign character it assumes in some cases suggests that it is at times a reversible or controllable physiological functional response, rather than an invariably progressive, irreversible pathological malignant mutation of the cells in the enlarged germinal centers.

Further Evaluation of Hydralazine in Treatment of Hypertensive Disease. R. D. Taylor, A. C. Corcoran, H. P. Dustan and I. H. Page. A. M. A. Arch. Int. Med **93**:705-712 (May) 1954 [Chicago].

Reappraisal of a group of hypertensive patients receiving continuous treatment with hydralazine as the sole antipressor agent confirmed the previously noted fact that only about half the patients in a group will respond favorably to the drug. Responsiveness, when present, may last for as long as 30 months. A favorable response to hydralazine is shown by a drop in the diastolic blood pressure and sustained improvement in the renal, cerebrovascular, and cardiac components of the severity index established at the time of the initial study. The greatest improvement was found in the renal status; some tendency toward progressive improvement was apparent in the cerebrovascular status; and improvement in cardiac status, though less than in either of the other two factors, was evidenced by the ability of patients who had had congestive heart failure to tolerate diets of normal sodium content. The most conclusive evidence of the effectiveness of hydralazine, however, is found in the mortality figures, which show only about one-fifth as many deaths among those who responded as among those who did not. The frequency with which a favorable response to therapy was found in patients whose hypertension seemed to be predominantly psychogenic supports the belief that hydralazine acts by suppressing a central vasopressor mechanism. The distressing side-effects often caused by the drug are usually transitory and can be controlled in most cases, although patients whose ultimate response is favorable may first have to pass through several weeks of discomfort. Trial periods should continue for at least eight weeks before being considered complete. Treatment should begin with doses of 25 mg. four times a day, increased slowly until a total of 800 mg. a day is reached or the desired effect is obtained at a lower dosage. The dosage should then be reduced gradually to the minimum amount needed to maintain the maximum therapeutic effect. Maintenance doses of 50 mg. four times a day seem at present to be completely and indefinitely tolerable. Much of the dissatisfaction sometimes expressed with hydralazine is apparently due to the large proportion of patients who do not respond to the drug, impatience in desiring a prompt depressor effect, overestimation of the significance of side-effects, lack of an ordered schedule of treatment, and reliance on casual blood pressure determinations in evaluating response.

Anticoagulants in Acute Myocardial Infarction. C. D. Hollis and R. B. Logue. J. M. A. Georgia **43**:412-416 (May) 1954 [Atlanta, Ga.].

Hollis and Logue review the literature, particularly Wright's controlled studies, and present several case histories to evaluate the use of anticoagulants in acute myocardial infarction. They feel that the clinician is still faced with the problem of whom to treat with anticoagulants. No precise indications can be deduced from the information available. In observing patients being treated with these drugs, one is impressed with the frequency of occurrence of embolic phenomena while the prothrombin time is within good therapeutic range, and with the incidence of significant hemorrhage when the patient is apparently under satisfactory control. It appears that anticoagulants may favorably affect the mortality and morbidity in certain situations. Each patient presents an individual problem. Those most likely to benefit from this therapy would fall into the following categories: 1. Patients with heart failure. Kerwin found that the reduction in mortality in his treated patients was confined to the group with heart failure. In patients without heart failure, mortality figures were approximately the same as in the control series. 2. Patients with a history of previous thrombophlebitis and pulmonary infarction, especially those with varicose veins. 3. Patients in whom shock has occurred. 4. Patients with auricular fibrillation. Under any circumstances, these agents are potentially dangerous. The physician using them should be aware of the risk involved, and the patient treated with them should be kept under close observation.

Acute Ischemia Syndrome of the Limbs and Arterial Reanimation. A. Lemaire, E. Housset, A. Maschas and others. Presse méd. 62:681-683 (May 1) 1954 (In French) [Paris, France].

Detailed reports of two patients with acute ischemia of the arm after venous irritation are presented. Cure was effected by the authors' method of injection under pressure of isotonic salt solution to restore normal arterial pulsations. While complete in both cases, the cures were interrupted by a technical error in one (a cannula was left in the inferior extremity of the radial artery) and sudden death from myocardial infarction in the other. In the authors' concept of the mechanism causing this syndrome, the notion of arterial inertia is not a primary one. Their opinion is that the inertia follows arterial spasm, the essential pathological feature of the syndrome. The persons who react in this abnormal way to venous irritation are (1) normal subjects whose hands and forearms have been immersed in cold water for a short while, (2) subjects who are apparently normal, but have definite vasomotor instability, as shown by plethysmography, and (3) subjects having a derangement in arterial tension, natural or induced. This is the largest class of patients.

Present Problems in Cushing's Disease: Based on Six Cases. J. Decourt, J. Guillemin, J. P. Michard and E. Baulieu. Semaine hôp. Paris 30:2001-2019 (May 20) 1954 (In French) [Paris, France].

Detailed reports are given of six patients with Cushing's disease or Cushing's syndrome. Five of these patients were women; this sex ratio is similar to that seen in larger groups. The syndrome is apt to have its onset after periods of great hypophysial activity such as puberty and pregnancy; this fact is presumed to account for the predominance of women patients. In this series, two women had symptoms beginning shortly after puberty, and three had symptoms occurring after pregnancy and aggravated by further pregnancies. Each patient may have a different pattern of symptoms from the long list included in the syndrome, which is easily diagnosed from the coexistence of several of the clinical and laboratory signs, all of approximately equal importance. Cushing's syndrome is characterized by generalized hypercorticism. The three groups of substances involved are the mineral corticoids, the glucocorticoids, and the sex hormones; unfortunately, no satisfactory correlation can be made between these groups and certain types of symptoms because there is much overlapping. There is also some evidence that a medullary hyperplasia may also exist in some cases. Laboratory studies revealed the following facts: 1. Disturbances in glucose metabolism occur in the syndrome, but are usually discrete. 2. Blood calcium and phosphorus may be disturbed; but no regular pattern of this could be found. 3. Also found were blood changes consistent with those produced by corticotropin or cortisone injections in a normal subject, i. e., lymphopenia and eosinopenia. These changes were particularly marked in two patients who had considerable amyotrophia and glycosuria. 4. Four patients had hypochloremia, and three had hypokaliemia. A very slight tendency to hypernatremia was noticed in a few patients. The tendency to hypochloremia and the elevation of the sodium chloride ratio seem to be frequent characteristics of Cushing's syndrome and proportional to its severity. 5. Determination of urinary steroids shows concurrent increase of metabolites coming from androgens and estroids on the one hand and from the corticoids on the other. It is difficult to tell in a patient whether the syndrome has its primary origin in the hypophysis, in which case it is true Cushing's disease, or in the adrenals themselves. The existence of melanoderma does not prove hypophysial origin. Radiography and retropneumoperitoneum may reveal no signs of tumor at either site. Roentgen therapy of the hypophysial region has very unsatisfactory results. It was entirely successful in causing complete remission in one of the authors' patients, but, in the other cases in which it was tried, there were some partial and some totally negative results. Exploratory lobotomy is justified in any case of Cushing's syndrome, even though doubt exists as to its origin. Even a unilateral adrenaloscopy is of value because if a hyperplastic, nontumoral gland is found, a working diagnosis of true Cushing's disease can be made; it can be assumed that an oversupply of corticotropin is being secreted by the hypophysis and the other adrenal is equally hyperplastic. If an atrophic adrenal is found, it can be assumed that a tumor is present on the other gland. Surgical removal of the hypophysis would probably be more effective than roentgen treatment; at present, this operation is restricted to those exceptional tumors large enough to compress the sella turcica or the optic chiasm. Bilateral partial adrenalectomy is the method of choice, if pituitary irradiation has been tried and has failed. This procedure was reasonably successful in one of the authors' patients. The death of one of the patients in this series, a woman of 23, was a factor in prompting the authors to state that, since Cushing's syndrome has a bad prognosis, evolves rapidly, and usually occurs in young persons, it requires radical treatment.

Cushing's Syndrome. B. Strickland. Proc. Roy. Soc. Med. 47:341-345 (May) 1954 [London, England].

Cushing's syndrome is due to the excessive formation of glucocorticoids by the adrenal cortex or by a tumor of the adrenal cortex. At operation or autopsy, the adrenals may appear normal or may show bilateral enlargement from simple hyperplasia, or a cortical tumor may be present. A few cases of Cushing's syndrome have been associated with tumors of the ovary, the thymus, or the pituitary. Whether these tumors are primary or secondary phenomena has not been established, but they are rare, and in the vast majority of cases the cause of Cushing's syndrome lies within the adrenal cortex. Every clinical manifestation of Cushing's syndrome can be reproduced by overdosage with cortisone or corticotropin (ACTH). Hyalinization of the basophil cells of the pituitary gland occurs commonly in Cushing's syndrome, but these changes are now regarded as secondary to the intrinsic abnormality of the adrenals. Osteoporosis and fractures are the main radiographic features of Cushing's syndrome. The author cites five cases of Cushing's syndrome in which particular attention was given to the radiographic aspects. All of the five patients showed fractures of ribs, three had fractures of the pubic rami, two showed fractures of the vertebral bodies, and one had a fracture through the femoral neck. The fractures, especially the rib fractures, must be looked for with considerable care. The whole skeleton should be radiographed, particularly the spine and the whole thoracic cage. These rib fractures are often quite unexpected clinically, even when multiple; thus 11 ribs were fractured in one case, 4 in another, 2 in another, 9 in a fourth, and 2 in a fifth, while only in one case did they feature in the clinical history or examination, and only in this one case were the ribs undeniably porotic. Although osteoporosis is regarded as a constant finding in Cushing's syndrome, its assessment is extremely difficult, for if the technical factors are altered only a little an apparent osteoporosis waxes and wanes in a most perplexing manner. Osteoporosis was present with certainty in only two of the five cases; this seems to suggest that rib fractures are commoner in Cushing's syndrome than fractures of the vertebral bodies, and fractures generally are a more constant finding than osteoporosis. Fractures of the pubic rami may be a commoner finding than previously supposed. The number and degree of fractures may not be closely related to radiographic evidence of osteoporosis, and there may be a difference in the skeletal changes resulting from cortisone overdosage and the changes seen in Cushing's syndrome as such.

See-Saw Relationship Between Hyperthyroidism and Myasthenia Gravis. B. Maclean and J. A. C. Wilson. Lancet 1:950-953 (May 8) 1954 [London, England].

The concurrence of hyperthyroidism with myasthenia gravis was reported in 1904 and thereafter, but it was pointed out in 1938 that external ocular paresis in association with thyrotoxic myopathy was often confused with myasthenia gravis and that doubt must, therefore, be cast on all cases in the absence of confirmatory neostigmine tests. Allowance must also be made for the observation by McEachern and Ross in 1942 that thyrotoxic myopathy itself shows a limited neostigmine response. In proved cases of the combination of these two

diseases, there has been considerable divergence as regards the effect of antithyroid treatment on the myasthenia gravis. Some reports indicate that partial thyroidectomy has either relieved or cured the myasthenia gravis, whereas investigators who found 4 persons with myasthenia gravis among 12,962 patients with exophthalmic goiter believed that antithyroid treatment produced no change in the myasthenic picture. On the other hand, a "see-saw balance" between the two conditions has been described, the signs of myasthenia gravis increasing as the signs of thyrotoxicosis diminish, and vice versa. The case described by the authors clearly demonstrated the see-saw relationship. Typical symptoms of thyrotoxicosis developed three months after confinement in a woman, aged 29. There was sweating, tremors, nervousness, weakness, loss of weight, diffuse thyroid enlargement, and bilateral exophthalmos. Treatment with methyl thiouracil controlled the thyrotoxicosis, but after eight weeks of such treatment, drooping of the right eyelid, weakness in the legs, and difficulty in swallowing was noted. When injection of a test dose of neostigmine abolished the ptosis, thiouracil treatment was discontinued, and two or three tablets daily, each containing prostigmine, 15 mg., were sufficient to control the signs of myasthenia gravis. Then the symptoms of thyrotoxicosis returned and thiouracil treatment was resumed. Within six weeks the thyrotoxicosis was satisfactorily under control, but the myasthenia gravis had become extreme, with drooping of both eyelids, general weakness, and slurring of the speech. The use of thiouracil was again discontinued, and the myasthenia gravis gradually improved at the expense of a mild recurrence of thyrotoxicosis. This see-saw between thyrotoxicosis and myasthenia gravis recurred several times more, but at the end of about four years the patient appeared to have achieved natural recovery, and she has needed neither thiouracil nor neostigmine since then. Neither thyrotoxicosis nor myasthenia gravis has recurred. Myasthenia coincident with thyrotoxicosis may be either thyrotoxic myasthenia or true myasthenia gravis. Antithyroid measures have directly opposing effects in these two conditions, relieving the thyrotoxic myasthenia and worsening the myasthenia gravis.

Nitrogen Mustard in Treatment of Systemic Lupus Erythematosus. E. L. Dubois. A. M. A. Arch. Int. Med. **93**:667-672 (May) 1954 [Chicago].

Nitrogen mustard was used in treating 20 patients with active acute and subacute systemic lupus erythematosus whose condition was deteriorating steadily in spite of maintenance therapy with cortisone. Renal damage was clinically apparent in 11 edematous patients with the nephrotic syndrome of lupus nephropathy, 8 of whom were benefited by the treatment, and in 2 others without edema. Neither the two nonedematous patients nor seven others in whom renal damage was not clinically discernible derived any benefit from the drug. Administration of the oral form of nitrogen mustard, triethylene melamine (TEM), was followed by the development of agranulocytosis in two of the five patients to whom it was given. One of these recovered after vigorous antibiotic and cortisone therapy, but the other died of aplastic anemia six weeks after the last dose of triethylene melamine. The unpredictable toxicity of this preparation contraindicates its use in lupus erythematosus. The only reactions noted from the intravenous form of nitrogen mustard were nausea and vomiting in about 80% of the patients receiving it and occasionally localized phlebitis. Transitory leukopenia that lasted for about a week appeared from 7 to 10 days after the intravenous administration of the drug, but in none of the patients did agranulocytosis develop when the intravenous form was used. Antibiotics were not given prophylactically while the leukocyte levels were low. Nitrogen mustard should be administered only after the patient's condition has been ameliorated as much as possible by cortisone, which exerts a beneficial effect on early renal damage in lupus erythematosus. Hormone therapy will usually correct high nonprotein nitrogen levels and abnormal urinary findings in critically ill, untreated patients, but, if renal damage and edema persist after a month or more of this form of treatment, in spite of a low-sodium diet and the use of mercurial diuretics, nitrogen mustard should be given a trial. Improvement, when it occurs, is reflected not only in the reduction of edema, but also in albuminuria, urinary sediment, and serum protein values, as well as in the over-all clinical picture.

Application of Tests of Liver Function to the Management of Viral Hepatitis with Jaundice. J. R. Kimmel, T. W. Burns, H. A. Harper and others. Gastroenterology **26**:723-733 (May) 1954 [Baltimore].

In 106 patients, most of whom were less than 30 years of age, with viral hepatitis, eight liver function tests, including serum bilirubin, thymol turbidity, sulfobromophthalein (Bromsulphalein) retention, cephalin-cholesterol flocculation, gamma globulin, zinc turbidity, phenol turbidity, and colloidal red test, were evaluated with respect to their applicability to the management of viral hepatitis. Discarded as being of little or no value in the management of viral hepatitis were the one minute (direct) serum bilirubin, the cephalin-cholesterol flocculation, the colloidal red, the zinc sulfate turbidity, the chemical determination of gamma globulin, the determination of phenol turbidity, and the icterus index. Three tests of liver function were retained as having great value in the management of hepatitis. These were the total serum bilirubin, the thymol turbidity, and the 45 minute sulfobromophthalein retention tests. These three tests were the biochemical basis of a system for the management of viral hepatitis, which was developed during the study of the 106 patients. During the acute (jaundiced) stage, the patient was at complete bed rest and on a high caloric, high protein diet; during this stage, only the determination of the serum bilirubin was necessary. After the patient was free of jaundice and entered the convalescent stage, gradual ambulation was permitted the patient, who was still on a high caloric, high protein diet; the weekly determination of serum bilirubin was continued in order to detect relapse as manifested by minimal hyperbilirubinemia; and, in addition, the sulfobromophthalein retention and thymol turbidity tests were performed weekly. In the typical patient during the weeks after jaundice disappeared, both the sulfobromophthalein retention and the thymol turbidity values gradually returned to normal; when figures for these tests fell below the upper limit of normal, i. e., 7% retention in 45 minutes and seven units, respectively, and if clinically the patient did not present prohibitive signs or symptoms, he was permitted full activity, placed on a regular diet, and discharged. Of the 106 patients studied, including 21 with presumed serum hepatitis, 42 had a normal convalescence, 38 were discharged well clinically, but with slight abnormalities in laboratory determinations (designated "probably normal"), and 12 had a convalescence of more than six weeks' duration with recovery. The remaining 14 patients had complicated convalescences, and 4 of these, who after several months of adequate trial on bed rest and appropriate diet, still had evidence of impairment in liver function either by physical examination or laboratory test, or both, were designated as having "chronic" hepatitis; one patient died of massive necrosis.

Contribution to Clinical Aspect of Periarteritis Nodosa. H. Kalk and E. Wildhirt. Deutsche med. Wchnschr. **79**:803-805 (May 14) 1954 (In German) [Stuttgart, Germany].

The occurrence of periarteritis nodosa is reported in a 56-year-old woman who for six months presented the clinical picture of recurrent jaundice similar to hepatitis. She was subicteric, the liver was slightly indurated on palpation, and the size of the spleen was normal. The blood cell count revealed 81% hemoglobin, 4,130,000 erythrocytes, 4,000 leukocytes, 30% lymphocytes and 2% monocytes. The methylene serum bilirubin, 1.95 mg. per 100 cc., was directly positive and the Takata test gave a negative result. The cadmium sulfate test, the thymol test and the formol-gel test gave negative results. The galactose tolerance test and the sulfobromophthalein (Bromsulphalein) test gave strongly positive results. Laparoscopy with liver puncture under direct vision was carried out. Macroscopic examination revealed signs of healed peritonitis in the upper abdomen with cord-like adhesions between the liver surface, gallbladder, omentum, and the anterior abdominal wall. The microscopic picture was that of partially

acute and partially healed periarteritis nodosa. The ophthalmoscopic examination revealed involvement of the vessels of the posterior part of the eye. There were no other abnormalities. The case of the patient was one of predominantly isolated involvement of the liver. Clinical recovery resulted from treatment with oxytetracycline (Terramycin), calcium methionine, 20 to 40% levulose (*d*-fructopyranose) solution (Laevosan), and vitamin B complex. A control puncture of the liver was done seven weeks after the first, and microscopic examination no longer revealed any periarteritic foci. It is suggested that a hepatic type may be added to the previously recognized types of this disease. Liver puncture is of great and even decisive significance in the diagnosis of periarteritis nodosa. There apparently are cases of periarteritis nodosa that do not run a fatal course, but in which clinical recovery may be associated with healing of the tissues of the affected vessels.

SURGERY

The Hematologic Response to Wounding and to Resuscitation Accomplished by Large Transfusions of Stored Blood: A Study of Battle Casualties in Korea. W. H. Crosby and J. M. Howard. Blood **9**:439-460 (May) 1954 [New York].

During the third winter campaign in Korea, the hematological reaction to wounding was studied in 37 casualties at the time of initial resuscitation. Of particular interest was the effect of massive transfusions of stored blood. The results of storage of blood—high plasma hemoglobin and potassium, low labile factor activity, nonviable platelets and leukocytes—had little deleterious effect on patients who received as much as 20 to 30 pints (10 to 15 liters) in less than six hours. The loss of transfused red blood cells because of nonviability was no more than expected. At the time of resuscitation and shortly thereafter, there was a remarkable loss of circulating erythrocyte mass in patients with wounds that involved much tissue destruction. It is believed that the loss was due to hemolysis, but the mechanism is unknown. The loss of red blood cells may be so rapid that a patient with bilateral traumatic amputation of the legs and an adequate hemostasis would become severely anemic if one hesitated to use large rapid transfusions. Patients with severe shock whose wounds involved less tissue damage (lacerated colon, for example) did not destroy red blood cells in this fashion. After moderate transfusions, such patients often became polycythemic. Transfusions had to be carried out rather gingerly because of a tendency for signs of congestion to develop. During the early days of recuperation from severe wounds, the patients often tended to become anemic. The anemia appeared to be the result of hemolytic processes plus a relative inhibition of erythrocyte formation. Universal donor blood, group O, was used in all transfusions. In patients who are not group O, the massive transfusions resulted in virtual replacement by red blood cells of another group. The patient's plasma sometimes contained antibodies against erythrocytes of his hereditary blood group. Gradual hemolysis of native red blood cells by transfused antibodies was observed. This was not a clinical hemolytic reaction and did not appear to be detrimental to the patient. The presence of the foreign antibodies made it impossible in some cases to cross match the patient's blood with blood of his hereditary group and suggested a source of danger in attempting such transfusions. After transfusion with the universal donor blood has begun, it is recommended that no change be made to blood of another group until at least two weeks have elapsed. No incompatible transfusion reactions were encountered. Several hemoclastic reactions may have been caused by gross contamination of the blood stream from the site of wounds or from the peritoneal cavity.

Carcinoma in a Newborn: Report of a Case. A. Dick. Am. J. Surg. **87**:673-675 (May) 1954 [New York].

Occurrence of carcinoma of the cheek is reported in a newborn baby boy. When the infant was 2 days old, a rash was noted on his face and the attending nurse felt a lump in his left cheek. This lump increased decidedly in size over the next month. When examined at the age of 6 weeks, the infant was well nourished, extremely active, and completely normal except for the swollen left cheek. At operation a mass the size of a pigeon's egg occupying the substance of the cheek was freed from the skin and the mucosa intraorally and was removed. Microscopic examination of the specimen revealed a small cell carcinoma of salivary origin. There seemed to be uneventful recovery until three weeks after the operation when a left submaxillary node was felt. The next day the mass was removed en bloc. Microscopic examination showed that practically all of the lymph node had been replaced by a malignant growth consisting of hyperchromatic epithelial cells with large nuclei and nucleoli. There was a large number of mitotic figures. After three months, the infant's mother noted some blood-tinged saliva when he drooled. A cytological study revealed malignant cells, and a localized mass was widely excised. The microscopic report was that of a very cellular growth with considerable anisocytosis, anisonucleosis, hyperchromatism, and presence of large nucleoli and frequent mitoses. After the three surgical procedures performed when the infant was between the ages of 6 weeks and 5 months, the child developed normally and at 18 months he weighs over 33 lb. (14.5 kg.), is well, and is apparently free of tumor. The microscopic study suggested that the site of origin was probably the parotid gland. Differentiation of the parotids is not complete until some time after birth. The embryonal origin theory, therefore, seems to find substantiation in this case.

Familial Distribution of Congenital Clefts of the Lip and Palate: A Preliminary Report. F. C. Fraser and H. Baxter. Am. J. Surg. **87**:656-659 (May) 1954 [New York].

A detailed family history was obtained of 57 male and 45 female patients with congenital clefts of the lip and/or palate visiting the clinic of plastic surgery of the Royal Victoria Hospital in Montreal, Canada. There was only one proband (the affected family member visiting the clinic) in each family. There were 131 normal siblings of the 70 probands with cleft lip with or without cleft palate and 9 siblings with a recurrence of the same defect, i. e., an incidence rate of 6.4%. In the group of 32 probands with isolated cleft palate, there were 98 normal siblings and 3 with a recurrence of the defect, i. e., an incidence rate of 3%. It was established that isolated cleft palate and cleft lip with or without cleft palate are genetically different entities. Analysis of the antenatal histories has not led to the identification of any relevant causative prenatal factors as yet. As a guide to the practitioner who has to advise the relatives of a child with cleft lip or cleft palate concerning the outlook for future members of the family, one could say that the risk that an unborn child would be affected is about 5% when either a parent or a sibling is affected and about 15% when both a parent and a sibling are affected. To know the true risk is of considerable help when trying to decide the difficult problem of whether to have more children.

Further Studies of the Physiological Principles Underlying the Treatment of Essential Hypertension by Surgery and the Thiocyanates. L. Davis, H. A. Lindberg, V. G. Bernhard and T. C. Douglas. Ann. Surg. **139**:560-566 (May) 1954 [Philadelphia].

To Davis and co-workers it appears to be more logical that in patients with essential hypertension the effect of sympathectomy, which denervates the celiac area, is the result of interference with the sympathetic nerve supply to the adrenal gland than the production of vasodilatation of vessels in the splanchnic area. Thus, it would be simpler to explain the improvement in the retinal changes following thoracolumbar sympathectomy on a change in hormonal influences mediated through the adrenal gland than on an anatomic change in the retinal vessels. These authors believe that in certain patients with essential hypertension sympathetic denervation of the adrenal gland is sufficient to reestablish the balance necessary to produce a state of normotension. In other patients with the severer diastolic type of hypertension, thiocyanates produce the same result, probably by producing a depletion of the sudanophilic granules present in the three layers of the adrenal cortex. For this opinion there seems to be histochemical evidence based on Deane's fundamental investigations on rats. In still another group of hypertensive patients, it becomes necessary to combine adrenal gland

denervation and depletion of the sudanophilic granules of the adrenal cortex by thiocyanates to improve the patient's symptoms. Partial occlusion of the portal vein caused disappearance of experimentally produced hypertension in dogs. Partial occlusion of the portal vein then was performed on two women aged 48 and 52 with hypertension. In one of these patients, there was no postoperative change in the blood pressure levels, but, after intravenous administration of thiocyanates, her blood pressure levels dropped to 170/90 mm. Hg. In the other patient postoperative blood pressure levels varied around 170/100 mm. Hg without any type of medication for six months and her liver function tests remained normal. The liver and adrenal glands may be out of balance in hypertensive patients, and partial occlusion of the portal vein influences the contribution of the liver to the mechanism. It is necessary to have more data on hypertensive patients with occlusion of the portal vein, more accurate methods of recording and evaluating the depletion of the sudanophilic granules in biopsy specimens of the adrenal cortex, more clinical evidence with certain hypotensive drugs that are said to be able to produce pharmacologic sympathectomies, and continued investigations of the reasons for the results obtained by sympathectomy in the treatment of essential hypertension.

Extended Exeresis of the Regional Lymph Nodes at Operation for Carcinoma of the Breast and the Result of a Five-Year Follow-Up of the First 98 Cases with Removal of the Axillary as Well as the Supraclavicular Glands. M. Andreassen, E. Dahl-Iversen and B. Sørensen. Acta chir. scandinav. **107:**206-213 (No. 2-3) 1954 (In English) [Stockholm, Sweden].

Since 1947, Andreassen and his co-workers have performed an extended radical operation for carcinoma of the breast in 98 consecutive patients with less severe lymphogenic invasion who according to Haagensen's criteria were operable and were followed up postoperatively for at least five years. The procedure chosen for this type of operation comprises removal of the axillary as well as the supraclavicular and parasternal lymph nodes in addition to the extirpation of the breast and the pectoral muscles. Of 100 additional patients operated on for carcinoma of the breast in the course of the past 10 months, 37 had medial and 63 had lateral carcinomas. Microscopic invasion of the axillary lymph nodes was observed in 41 patients; 3 (7%) of the 41 patients had microscopic invasion of the supraclavicular lymph nodes and 13 (32%) had microscopic invasion of the parasternal nodes. In four patients with medial carcinomas, metastases occurred only parasternally. Metastases to the parasternal lymph nodes occurred in 11 of the 37 medial but in only 6 of the 63 lateral carcinomas. The supraclavicular metastases occurred only in the lateral carcinomas in this series. Of the 98 patients with carcinoma of the breast who underwent extended radical operation after 1947, 47 were without microscopic metastases to the axillary lymph nodes and 51 presented such metastases. Macroscopically demonstrable metastases to the supraclavicular lymph nodes were observed in none of these 98 patients. All these patients were given roentgen irradiation treatment postoperatively in the axillary, parasternal, and supraclavicular regions. In 17 of the 98 patients, microscopic invasion of the carcinoma was found in the supraclavicular lymph nodes; all 17 had microscopic metastases to the axillary lymph nodes; and 11 of the 17 were operable according to Haagensen's criteria. The five year follow-up of the 98 patients revealed 12 recurrences among the 47 patients without microscopic metastases to the axillary lymph nodes, i. e., a freedom-from-recurrence rate of 74%. There were 40 recurrences among the 51 patients with microscopic metastases of the axillary lymph nodes, i. e., a freedom-from-recurrence rate of 22%. Of the 17 patients in whom microscopic metastases to the supraclavicular lymph nodes were demonstrated at operation, 3 (18%) were free from recurrence. Two of these three patients were among the 11 who were operable according to Haagensen's criteria, whereas the third belonged to the group classified as inoperable according to these criteria. The remaining 14 patients died of metastases from the carcinoma within from six months to four years after the operation. Prophylactic removal of the axillary lymph nodes and fatty tissue thus cannot alone improve the five year freedom from recurrence, even though the authors' series included three cases with no recurrences for five years among 17 patients with microscopically demonstrable metastases to the supraclavicular lymph nodes. Microscopically demonstrable invasion of the supraclavicular lymph nodes cannot be regarded as indicative of inoperability as a five year freedom from recurrence was found in 18% of such cases treated with removal of these lymph nodes.

Pulmonary Blebs and Bullae. J. R. Massie and G. A. Welchons. Ann. Surg. **139:**624-634 (May) 1954 [Philadelphia].

The occurrence of pulmonary blebs and bullae is described in seven patients between the ages of 28 and 60. Symptoms consisting of moderate to severe dyspnea were improved by thoracotomy with excision of the air-filled cysts and closure of their bronchiole communications in five patients and upper lobectomy in one patient. One patient died after a needle was inserted into the air cyst; in retrospect this patient possibly could have been saved by an immediate thoracotomy. The insertion of a needle into an emphysematous cyst is dangerous and rarely necessary, but, should it be done, there should be available suction and operating rooms for thoracotomy if trouble develops. Excision of blebs and bullae is a relatively safe procedure and offers much to dyspneic patients, often enabling them to resume their usual occupations that they had to abandon because of incapacitating shortness of breath. Surgical intervention should also be considered as a method of preventing spontaneous pneumothorax, even in nonsymptomatic air cysts. As much normal or near normal pulmonary tissue should be preserved as possible, for it must be remembered that many of these patients already have pronounced decrease in lung reserve owing to an accompanying emphysema. It is rarely necessary to remove as much as an entire lobe. Previously unobserved good pulmonary tissue often reexpands after removal of tension cysts, and its preservation is important.

Follow-Up Three Year Clinical Results of Combined Subtotal Gastrectomy and Subdiaphragmatic Vagotomy in 108 Cases of Duodenal (and Jejunal) Ulcer: (Comparison Also of Results Obtained with Gastroduodenal and Gastrojejunal Types of Anastomosis). J. I. Baltz, L. S. Fallis, J. G. Mateer and J. Barron. Gastroenterology **26:**533-547 (April) 1954 [Baltimore].

Of 128 patients with duodenal or jejunal ulcer in whom a combination of subtotal gastrectomy and bilateral subdiaphragmatic vagotomy was done between 1946 and June 30, 1951, 2 (1.6%) died of the surgical intervention, 6 died of unrelated causes, 12 had an inadequate follow-up, and 108 were followed for an average of 38 months after the surgical intervention. Of the 108 patients followed up, 93 (86.1%) obtained excellent results as they remained free from all gastrointestinal symptoms, felt generally well, and returned to work. Fairly good results were obtained in 11 patients (10.2%) and poor results in 4 (3.7%). There was only one recurrent ulcer in the 108 patients; this ulcer healed promptly with medical treatment and remained healed. A much longer period than 38 months of follow-up will be necessary to draw final conclusions as to the value and advisability of combining vagotomy with subtotal gastrectomy in an effort to prevent recurrent ulcer. The authors' study strongly suggests that the addition of vagotomy to subtotal gastrectomy contributes valuable protection; they feel that this procedure should be done at the original operation and not reserved for the unfortunate patient in whom a jejunal ulcer develops after gastric surgery. The addition of vagotomy to subtotal gastrectomy may increase slightly the postoperative morbidity. However, the practical importance of the postoperative delay in gastric emptying can be strikingly decreased by jejunal feeding according to Barron's technique. A very small polyethylene tube is introduced into the jejunum at the time of the operation, and finely homogenized food of a balanced diet can be introduced directly into the small intestine, with ease, at the proper time after the operation. Results of postoperative gastric analysis were highly satisfactory. At an average time of 24.5 months after the operation, 31 (88.6%) of 35 patients tested showed achlorhydria with bread and broth stimulation, and 22 (80%) of 28 patients showed achlorhydria with histamine stimulation. Ten patients were tested more than three years after the operation. In 68 of the 108 patients, a gastroduodenal anasto-

mosis was established, and in the remaining 40 a gastrojejunal type of anastomosis was performed. The patients with gastroduodenostomy comprised before the operation twice as many with jejunal ulcers in whom the most unsatisfactory results can be expected. Despite this, the percentage of "excellent results" was practically the same in both groups. Poor results were obtained in 4 (5.9%) of the 68 patients with gastroduodenostomy, while there were no poor results in the gastrojejunostomy group, but this difference is not statistically significant. The total evidence at hand does not indicate the superiority of either procedure, but the authors continue to do the gastroduodenostomy when the stomach can be properly mobilized and the anastomosis made without stress. At least a five year follow-up will be necessary to reach final conclusions regarding the relative merits of these two types of anastomoses.

Changes in Arterial Tone After Ganglionectomy. A. Puglionisi. Minerva chir. **9**:193-199 (March 15) 1954 (In Italian) [Turin, Italy].

The effects of ganglionectomy or sympathectomy on the arterial tone in, and on the blood flow through, the skin of the toes and fingers in patients with diseases of the peripheral vascular system were studied. The venous congestion test according to Hewlett and Zwaluwenburg was used together with a plethysmograph made by the author on the principle of Goetz. The preoperative test was carried out at the time of admission and after the patient had rested for 60 minutes at room temperature with the extremities uncovered. At the same time the skin temperature was recorded. A lumbar ganglionectomy with removal of the second and third ganglions was performed in all but two patients (one with arteriosclerosis and one with Raynaud's disease). In these, a sympathectomy of the right arm was performed according to Smithwick's technique. The postoperative blood flow and skin temperature were determined at the time of discharge and several times thereafter. The results indicated that both were markedly increased. In a follow-up two years later they were still much higher than the preoperative values. The blood flow was reduced in some patients on the first postoperative days, but increased several days later. The changes in the blood flow depended on two factors—the degree of sympathetic hypertonia present before the operation and the extent of the anatomic lesion. In many patients, the digital pulsation was markedly increased for a long time. Unlike many authors, Puglionisi found that the arterial tone was decreased and persisted as such. To explain this contrasting finding, he says that authors who reported an increased arterial tone had studied either the entire extremity, the hand, or the foot, and the plethysmograph had included both the muscles and the skin. In his studies, only the digits were considered, and in the skin of the fingers and the toes the arteriovenous anastomoses are the most numerous. It may be that these arteriovenous anastomoses remain permanently dilated after sympathectomy or ganglionectomy.

Plastic Operation of Hahn-Brandes. J. Fischer-Wasels and R. Wilde. Ztschr. Orthop. **84**:393-407 (No. 3) 1954 (In German) [Stuttgart, Germany].

Fischer-Wasels and Wilde are concerned with severe forms of pseudarthrosis of the tibia in which defects of from 10 to 20 cm. in length have to be bridged and in which there is a poor healing tendency. In the past, amputations were done in many of these cases. Hahn in 1884 had developed a plastic operation particularly designed for these severe pseudarthroses with extensive defects of the tibia. He performed osteotomy of the homolateral fibula immediately below its head and implanted the fibula into the newly débrided medullary cavity of the tibia. In the largest defects, Hahn recommended also a lateral freshening of the tibia and fibula. In 1913 Brandes of the Anschütz Clinic described a modification of this method. He had observed that implantation of the proximal end of the fibula was not quite adequate in some cases, in that defective position and limitation of movement of the foot joints resulted in some cases. For this reason, he decided to implant also the distal end of the shaft of the fibula into the lower portion of the tibia; that is, the entire shaft of the fibula was transplanted into the large defect of the tibia. Anschütz, who also used this method and reported late results after up to 15 years follow-up, mentioned in one of his reports that the modification used by Brandes had been described in 1906 by Stone and in 1912 by MacAusland and Wood. The authors of this paper report the histories of five patients in whom they used this method. They obtained excellent results in severe pseudarthrosis of the tibia with extensive defects. They feel that this operation is not as well known as it should be, in view of its excellent results.

Surgical Treatment of Mitral Stenosis with Emphasis on Case Selection. W. A. McAlpine and R. E. Beamish. Manitoba Med. Rev. **34**:261-264 (May) 1954 [Winnipeg, Manitoba, Canada].

Although commissurotomy has gained universal acceptance as a vital adjunct in the treatment of mitral stenosis, the operation is not indicated in every patient with this disabling and frequently fatal disease. Before operation is decided on, one must carefully consider the patient's present status and prognosis without operation and the risk of, and the results to be obtained from, surgical intervention. The presence of progressive symptoms such as dyspnea, coughing, and hemoptysis indicate a high grade stenosis of the mitral valve, the definite treatment of which is commissurotomy. The aims of surgery are the relief from symptoms and functional restrictions and the prevention of the serious sequelae of the obstruction of the valve such as heart failure and occurrence of fatal peripheral or pulmonary emboli. Rheumatic fever, subacute bacterial endocarditis, uncontrolled heart failure, and associated functionally significant valvular lesions contraindicate mitral commissurotomy. Mitral commissurotomy in the presence of auricular fibrillation carries a higher risk than in patients with normal sinus rhythm because of the more advanced stage of the disease and the risk of thromboembolism in relation to surgery; because of the severity of the obstruction, surgical treatment provides, however, the only satisfactory solution. When the size of the heart is greatly "enlarged," the myocardium is irreversibly damaged and surgery has no place. In regard to surgical technique, great care must be taken to avoid cerebral embolism in the course of the operation. In the 28 patients operated on by one of the authors, the innominate and carotid arteries were dissected out at their aortic origin according to Bailey's technique and were occluded to prevent cerebral embolism. Intracardiac manipulation was performed only during a period of intermittent occlusion, never exceeding 90 seconds. Cerebral emboli did not occur in any of the 28 patients, although auricular fibrillation preexisted in most of them, and 9 patients had a history of cerebral embolism. Freedom from the latter is attributed to this procedure. The auricular appendage provided an excellent approach for intracardiac surgery. Gravimetric estimation of blood loss was used routinely; the blood loss varied between 140 and 600 cc., being much less than that observed in most other major operations. The principles in commissurotomy are sound; hence it is not surprising that the results are good and the risks are small. Of the 28 patients, only 2 seriously ill patients died; in these 2 the valve could not be opened with dispatch. The excessive periods of anoxia produced irreversible changes. In one patient, the appendage was a small calcified mass, necessitating use of the superior pulmonary vein to enter the heart. The latter approach is much more time consuming. A similar problem existed in the other fatal case. An additional patient with extensive auricular calcification, which made commissurotomy impossible, died on the 14th postoperative day, suggesting that a seriously ill patient will not tolerate surgical treatment if no physiological improvement results.

Bronchial Adenoma Occurring in the Bronchial Stump Following Lobectomy. H. D. Hilton and H. Tanner. Nebraska M. J. **39**:202-204 (May) 1954 [Lincoln, Neb.].

Hilton and Tanner present the case of a woman in whom the lower lobe of the right lung was removed in 1948 because of lipoid pneumonia. The stump of the bronchus was removed in 1952, because of intractable cough and recurrent hemoptysis. The stump was found to be the site of a bronchial adenoma. The authors were unable to find a similar case report in the

literature. They feel that the possibility that a neoplastic process may develop in the bronchial stump should be thought of, if cough and hemoptysis persist after pulmonary resection. If the usual diagnostic procedures give inconclusive results, the patient should be subjected to exploratory thoracotomy.

NEUROLOGY & PSYCHIATRY

Multiple Sclerosis in Children. M. Bonduelle, P. Bouygues and C. Sallou. Presse méd. **62**:563-564 (April 14) 1954 (In French) [Paris, France].

Multiple sclerosis is rare in children, but some true pediatric cases have been reported. The authors maintain that this diagnosis must be made very carefully, in view of the similarity of the symptoms of multiple sclerosis to those of hereditary syphilis, hereditary cerebellar ataxia, Leyden's ataxia, and some of the leukoencephalitic diseases formerly called "acute disseminated encephalomyelitis." One well-tabulated case is presented in which there was no doubt that the disease that began in a boy of 7 and was followed by the authors for 12 years was actually multiple sclerosis. Since the differential diagnosis of multiple sclerosis in children depends principally on noting the manner of evolution of their disease, a long period of investigation is essential. Multiple sclerosis in children often occurs in atypical forms, though the disease process can resemble that seen in young adults. Study of this disease in children is necessarily limited to the chronic forms.

Management of the Multiple Sclerosis Patient. A. Dekaban. Canad. M. A. J. **70**:502-509 (May) 1954 [Montreal, Canada].

Dekaban feels that most of the remedies introduced for multiple sclerosis are based on wishful thinking. A physician who accepts a multiple sclerosis patient, particularly in the early stages of the disease, takes on an enormous responsibility. He is the only one who is qualified to impose upon the patient and his family suggestions related to the organization of the patient's future (including possible change of occupation). To fulfill this role, the physician must possess commonsense and knowledge of life and must also be thoroughly acquainted with the clinical course of this disease. The author analyzes the most important aspects of the management of the patient with multiple sclerosis —the diagnosis and its communication to the patient, instructions to the family, the medical management, and rehabilitation by physical medicine and occupational therapy. Most of the procedures recommended are not new and have been applied not only in multiple sclerosis, but also in disabilities from other conditions. A realistic, practical attitude, with long-term foresight of occupational adjustment is of great importance, because, even if finally the proper treatment for multiple sclerosis is found, the long-standing disability of the present patients could not be altered.

The Management of Poliomyelitis. P. Barsky. Canad. M. A. J. **70**:517-520 (May) 1954 [Montreal, Canada].

Barsky analyzes observations on 250 patients with poliomyelitis admitted to the Children's Hospital of Winnipeg in 1952. The patient was first examined in the outpatient department. There his involvement was assessed, lumbar puncture done if required, and the patient transferred to the ward. It was not possible to admit all patients with poliomyelitis to the hospital. It was felt that those who showed only some minor weakness would be better off with intelligent guidance at home. At the onset of the epidemic lumbar punctures were done in all cases, but the results of 150 tests revealed that there was no correlation between the severity of the poliomyelitis and the cerebrospinal fluid cell count. Some with severe bulbar cases had low counts or no cells in the cerebrospinal fluid. Some with spinal cases with high cell counts made a more satisfactory or uneventful recovery. None of the patients showed elevation of pressure or of protein or chlorides. It was decided, later in the epidemic, to perform spinal puncture only when the diagnosis was in doubt. Mild analgesics were used to counteract muscle pain. Hot fomentations were beneficial in relieving muscle pain. Care was taken to maintain a correct fluid and electrolyte balance. The outstanding characteristic of this epidemic was the heavy predominance of bulbar cases, 50 cases (20%) being bulbospinal and bulbar in type. Twenty-five patients (10%) required respirator care for up to several months' duration and eight patients (3.2%) required tracheotomy. There was a high rate of contact cases and of multiple cases in families. The severest cases occurred in families in which more than one member had poliomyelitis. The incidence was highest among the children 4, 5, and 3 years old. Thirteen children were less than 1 year old. Whereas in previous outbreaks in this region the peak was reached in the middle of August, in 1952, although the first cases appeared late in June, the peak of the epidemic was not reached until the middle of October, and cases occurred steadily until mid-December. Although the highest incidence of cases occurred in the younger age groups, the older children from 9 to 15 years had much more acute symptoms. The incidence of paralysis was higher in the older groups. The virus strain isolated was identified as the Brunhilde type.

Mysoline in Epilepsy. L. M. Pence. Texas J. Med. **50**:290-292 (May) 1954 [Fort Worth, Texas].

Primidone (Mysoline) is closely related to phenobarbital but belongs to a chemical type not used previously as an anticonvulsant drug. Pence used primidone in the treatment of 48 patients for from 6 to 26 months. Previously these patients had received various anticonvulsants without achieving control. Forty-two of the 48 patients are still taking primidone. The other six have been dropped from the study, three because they received no benefit from primidone and the other 3 because they failed to return. Primidone was used alone in 11 patients; in the other 37 patients it was combined with various other anticonvulsants. Most patients required three tablets per day; however, many required five or six, and one patient required nine per day. Combination with another anticonvulsant sometimes permitted a reduction in dosage. The best results were obtained with primidone given alone or combined with a hydantoin or a barbiturate. Results obtained were excellent in 32 of 48 patients and 10 other patients were improved. Practically all anticonvulsant drugs will produce toxic effects if used in large enough amounts, and primidone is not an exception, but it appears that its anticonvulsant action is great enough so that relatively nontoxic doses may control seizures.

The Surgery of Epilepsy: Based on 35 Operated Cases. J. Courjon, J. Lecuire, L. Mansuy and others. Lyon chir. **49**:257-268 (April) 1954 (In French) [Lyon, France].

Epileptic patients must be selected carefully for surgery. A high degree of selection was practiced in order to obtain the present series of 35, and only 6 were cured and 11 significantly improved. A further 4 were very slightly improved, 11 were completely unchanged, and 3 died. Nineteen of the patients had temporal, 8 frontal, 6 rolandic, and 2 parietal foci. Electroencephalography is essential to the selection of these cases. The following criteria must be met. 1. A focus of points must be found that is not pseudorhythmic in character, that remains absolutely constant from one examination to the next, that is not bilateralized during sleep, and that is not influenced by stimulation with light. 2. The basic rhythm in other regions must be fairly regular. 3. An elevated cardiazolic threshold must exist, except in patients with frontal foci, or there must be a very late diffusion during such stimulation. 4. There must be a correspondence between the permanent site of the focus and that of the attack provoked by cardiazolic stimulation. 5. There must be a correspondence between the site of the focus and the clinical data. Surgical treatment is reserved for those whose symptoms have not yielded to long-continued medical treatment and who have had a number of concordant electroencephalograms over a period of time.

Malignant Cells in Cerebrospinal Fluid. A. I. Spriggs. J. Clin. Path. **7**:122-130 (May) 1954 [London, England].

Spriggs cites histories of seven patients in whom tumor cells were recognized in the cerebrospinal fluid during life. In six cases, there was postmortem proof of meningeal dissemination of malignant growth, and in the seventh necropsy was refused. Of the six completely studied patients, two had primary cerebral

tumors (a glioblastoma multiforme and a medulloblastoma), two had adenocarcinoma, one had a reticulosarcoma, and one had a myeloma as the primary growth. A review of the literature revealed 66 additional cases in which tumor cells had been detected in the cerebrospinal fluid. During the period when the seven cases were seen, air-dried films stained by Romanowsky stain were made only if unusual cells were seen in the counting chamber or if the examination for malignant cells was requested. It is likely that other cases were missed, owing to failure to make stained films in all cases of pleocytosis. Application of the Papanicolaou method to the cerebrospinal fluid has not proved very satisfactory, and wet chamber methods have the serious drawback of impermanence. Malignant cells cannot be distinguished by any single morphological feature, but in the case of cerebrospinal fluid there is not a very large variety of cell types from which tumor cells have to be distinguished, and in well-stained films the diagnosis is sometimes obvious. The diagnosis is based on the following principal criteria. 1. The cells are foreign to their environment; they differ from any type of cell occurring in the cerebrospinal fluid in other conditions. 2. The cells morphologically resemble those seen in particular varieties of tumor. 3. The cells may show some of the features characteristic of tumor cells in general. Of these the most noteworthy are large size, especially of the nucleus, high nucleocytoplasmic ratio, reduplication of nuclei, enlargement of nucleolus, great variation in size and shape of otherwise similar cells, and frequent mitoses. These features are not present in every case, and none by itself is of particular significance.

GYNECOLOGY & OBSTETRICS

Relations of Chronic Cystic Mastitis and of Fibroadenoma of Breast to Mammary Carcinoma. L. Severi. Ztschr. Krebsforsch. **59:**679-686 (No. 6) 1954 (In German) [Berlin and Munich, Germany].

This report is based on 466 cases of fibroadenoma, 128 of chronic cystic mastitis, 33 of carcinoma developing from fibroadenoma, 77 of carcinoma developing from cystic mastitis, and 295 mammary carcinomas that had no connection with either fibroadenoma or cystic mastitis. In addition to these cases, which were observed at the tumor center of Perugia, Severi considers literature reports. He arrives at the conclusion that, as regards morphology, fibrocystic mastitis as well as mammary fibroadenoma are precancerous tissue changes from which special cancers may develop. He concludes that 16.09% of breast carcinomas develop from fibroadenomas; 37.56% develop from chronic cystic mastitis; and 46.35% develop independently of fibroadenoma or cystic mastitis. Observations indicated that the development of a carcinoma from a fibroadenoma requires about 20 years, of a carcinoma from cystic mastitis 8 years.

The Artificial Menopause: With Special Reference to the Occurrence of Spinal Porosis. I. A. Donaldson and J. R. Nassim. Brit. M. J. **1:**1228-1230 (May 29) 1954 [London, England].

Two groups of patients were studied—94 women who had been subjected to an artificial menopause by either surgery or radium and 28 women who attended the hospital because of backache and were found to have spinal porosis. Twelve of 91 in the first group had radiological evidence of spinal porosis; 3 were not examined radiologically. None of the poroses was of greater severity than grade 1; this can be considered physiological in three of the patients because they were over 65 years old. In the second group of women, the average length of time after menopause, whether natural or artificial, was 18.4 years. There was no evidence that osteoporosis of significant degree is precipitated by an artificial menopause or that it occurs at an earlier age after an artificial menopause. The occurrence of postmenopausal osteoporosis is unpredictable; its time of onset or its severity is not related to the age at which menopause, natural or artificial, occurs or to the number or frequency of pregnancies. The tendency for the serum phosphate level to be raised in patients with fully developed porosis was confirmed by this study. There was no evidence that hypertension is attributable to the artificial menopause. An increase in weight occurred in most of these patients, but there was no increase or even a decrease in 26.5%. Hot flushes occurred in approximately 75% of patients, and their duration varied between 4 and 24 months. The incidence is higher and the duration tends to be shorter in the younger age groups. There was no significant difference between the patients who had a surgical and those who had a radium-induced menopause. The incidence and duration are similar to those following the natural menopause in comparable age groups. After an artificial menopause, libido was decreased in approximately 65% of patients. The fact that the ovary is not essential to the maintenance of libido is shown by the percentage of patients who were unaffected. This investigation emphasizes that the only two constant effects of removal of the ovaries are amenorrhea and sterility.

Obstetric Paralysis of Leg. O. R. Marattoli and F. Celoria. Rev. Asoc. méd. argent. **68:**24-26 (Jan.-Feb.) 1954 (In Spanish) [Buenos Aires, Argentina].

The authors warn against the injection of coramine into the umbilical cord of infants born with neonatal asphyxia. The injection of coramine into the arteries of the umbilical cord is a frequent cause of obstetric paralysis of a leg, often combined with a zone of ischemia in the gluteal region that may become necrotic. The symptoms of the disorder appear one or two days after birth. There is general edema of the leg and foot drop. Peripheral flaccid paralysis of the external popliteal sciatic nerve is identified by stimulation. Paralysis may regress to complete recovery in six or nine months, or it may remain permanent. The treatment consists of correction of the paralysis by splints, orthopedic apparatus, or prostheses. From 1950 to 1953, the authors observed seven cases of obstetric paralysis of the external popliteal nerve. All infants were born with neonatal asphyxia and had coramine injections into the umbilical cord. The treatment according to this scheme gave good results. The authors emphasize the importance of differential diagnosis of the origin, central, peripheral, or mechanical, of the syndrome. In five out of the seven patients, the paralytic syndrome was of peripheral origin. In one case, neurography of the external popliteal sciatic nerve showed a ring of fibrous tissues making compression on the nerve. Complete relief of paralysis followed liberation of the nerve after extirpation of the fibrous tissue. In another case, a diagnosis of a large hematoma in the right frontoparietal region was made. Evacuation of the hematoma controlled the neurological symptoms of central origin with complete regression of paralysis.

PEDIATRICS

Subdural Hematoma in the Infant Associated with Fractures of the Limbs. J. Marie, P. Apostolidès, J. Salet and others. Semaine hôp. Paris **30:**1757-1763 (April 30) 1954 (In French) [Paris, France].

The authors add a new case of subdural hematoma associated with limb fractures, occurring in a girl of 4½ months, to the 10 cases in the literature. The cause of this syndrome is not known, nor is the relationship between hematoma and fractures clear. The condition is seen in both sexes at ages ranging from a few weeks to several months. The subdural hematoma is always bilateral; in most cases, it heals without sequelae. The multiple fractures are usually located in the diaphyses and metaphyses of the long bones and are frequently accompanied by considerable displacement and large subperiosteal hematomas. The fractures do not occur simultaneously, but at two or more intervals of from a few weeks to several months. There is no fixed chronological order of the occurrence of the hematoma and that of the fractures. The appearance of the fractures is often accompanied by ecchymoses and petechiae disseminated all over the body. The fractures may be caused by trauma, although there was no history of it in the cases reported. It could have gone unnoticed by the parents. Obstetric trauma was a possible factor in only one of the 11 cases, but it is interesting to note that in the 2 cases in which fractures appeared very early in life, the babies were the result of cesarian deliveries. Nutritional deficiency was present in no case, and there was no radiographic evidence of bone fragility.

Mitral Commissurotomy in Childhood. P. R. Lurie and H. B. Shumacker. Pediatrics **13**:454-461 (May) 1954 [Springfield, Ill.]

The authors describe the case histories of three pediatric patients, aged 12, 14 and 15, respectively, as proof that the same indications for mitral commissurotomy that are found in adult patients may sometimes exist in this younger age group. Great care was taken to disprove the existence of active rheumatic carditis and intractable right heart failure, the two main contraindications to mitral surgery in childhood. The operation occasioned dramatic remissions in the clinical condition of this boy and these two girls, although auscultatory signs of mitral insufficiency were still present immediately after surgery or developed a short time later. Lack of previous experience with such patients and especially lack of adequate follow-up prevents the formulation of an accurate prognosis for these children, but it is felt that commissurotomy at their time of life was extremely valuable to them, particularly as the valves were still very supple and functioned well after finger fracture, thereby relieving the patients' presenting symptoms. If another operation proved to be necessary later in life, the surgical prognosis might well be improved by the fact that the patient had already had a commissurotomy in childhood.

The Peptic Ulcer Problem in Infancy and Childhood. R. B. Tudor. Journal-Lancet **74**:189-191 (May) 1954 [Minneapolis].

Tudor observed peptic ulcer in 14 children, ranging in age from 5 days to 15 years, and duodenitis in 7 children from 6 to 13 years of age. A review of the literature disclosed that, including Tudor's own cases, a total of 481 cases of peptic ulcer in children have been reported. In the newborn and in infants the mortality of peptic ulcer is 90%. The author's cases included two infants, 5 days and 23 days old, respectively; both died. Ulcers in children beyond infancy respond to a bland diet and an effective antacid such as calcium carbonate. The author believes that peptic ulcer is common during childhood and that infants with cyanosis and abdominal distention and older children with recurrent abdominal pain should be subjected to a thorough radiological examination of the stomach and duodenum to rule out this lesion. Duodenitis in children cannot be distinguished from peptic ulcer on a purely clinical basis.

Streptomycin Treatment of Tuberculous Meningitis in Children: A Long-Term Follow-Up Study. J. S. Oldham, B. D. Bower, I. J. Carré and O. H. Wolff. Tubercle **35**:102-108 (May) 1954 [London, England].

The authors report on 122 children with tuberculous meningitis whose average age was 4 years and 3 months and who were given streptomycin or dihydrostreptomycin at the Birmingham Children's Hospital between 1947 and July 1, 1953. Ninety-two of these provided data for the conclusions concerning prognosis. Before 1950, treatment consisted of an interrupted course of streptomycin; the dose employed was 20 to 30 mg. per pound of initial body weight per day, with a maximum dose of 2 gm. daily given in two daily intramuscular injections. Streptomycin was given intrathecally on alternate days in a dose of 50 mg. for children aged less than 3 years and 100 mg. for older children. Each four week period of treatment was followed by one week's rest; at least three such courses were given. In the last two years, streptomycin or dihydrostreptomycin was given intramuscularly twice daily for a minimum uninterrupted period of 120 days and intrathecally daily for at least 90 days. The dose remained the same. Treatment was continued for longer periods in patients in whom clinical progress was unsatisfactory or in whom the cerebrospinal fluid had not returned to normal. Of the 92 patients, 35 (38%) are still alive and were followed for two to six years. Seventeen of the 35 made a complete and uninterrupted recovery. Nine children had relapses; three of the nine are still under treatment and, although their progress is satisfactory, the eventual outcome remains doubtful. Fourteen of the 35 survivors have some residual disability; 2 are mentally defective, one has a spastic paraplegia, and one a mild hemiparesis. Twelve children show some degree of hearing loss. This high incidence of residual deafness seemed to be closely associated with the use of dihydrostreptomycin. It is likely that a higher total dosage of streptomycin was given by the intrathecal route than has been usually employed. As the authors' results are no better than those reported by others, it is doubtful if there is any justification for such intensive intrathecal therapy. The changes in sugar and chloride content of the cerebrospinal fluid obtained at the last lumbar puncture immediately preceding treatment were analyzed in 88 children. The lowest recovery rate was observed among those children in whom both sugar and chloride levels were below the median. The degree of change in the cerebrospinal fluid before treatment is begun may be of real help in assessing prognosis. The relatively small number of complete recoveries and the occurrence of relapses after several years of good health warrant the conclusion that the results of treatment of tuberculous meningitis with streptomycin intramuscularly and intrathecally reflect the need for more effective therapeutic measures and for a long-term follow-up period before the final results of treatment can be assessed.

DERMATOLOGY

Xanthosis Cutis in Poliomyelitis. H. W. Linn. M. J. Australia **1**:581-588 (April 17) 1954 [Sydney, Australia].

Among 2,500 patients with poliomyelitis, only rarely was one not found to have some degree of xanthosis cutis in the acute phase of the disease. This condition, which consists of a high, dusky flush of the cheeks on a yellow background of varying intensity, was also noticed consistently in patients who had encephalitis during an attack of mumps, measles, infectious mononucleosis, or endemic typhus. In the course of experiments carried out in an attempt to find the cause of this yellow skin pigmentation, the following observations were made. 1. The serum lipochrome indices were not grossly abnormal. 2. Most serum carotene levels were within normal limits; however, a few were raised. 3. When the palms of patients with poliomyelitis or encephalitis associated with mumps, measles, infectious mononucleosis, and endemic typhus were exposed to filtered ultraviolet light, a yellow-green fluorescence was observed that differed considerably from the normal dusky-blue color. It was identical with that emitted by the albumin fraction of the human serum which previously was reported by other workers to contain all the carotene in the blood. No other substance was observed to give this same peculiar fluorescence. 4. Examination by fluorescence microscopy of fresh skin sections from patients with poliomyelitis showed that this pigment occurred only in the horny layers of the skin. It was shown by other workers that carotene was present only in the horny layer of normal skin. It is suggested that an early rise in serum carotene level occurs several days before the patient feels ill enough to consult his physician and be admitted to the hospital. Most patients with poliomyelitis show evidence of considerable overaction of the sympathetic nervous system. The excessive secretion of thyroxin as a result would mobilize carotene and vitamin A from the liver, as they are antagonists of thyroxin. This would account for the mobilization of carotene that is presumed to occur in the early stages of poliomyelitis. As the condition progresses and the temperature rises, the blood carotene levels will fall and be within normal limits at the patient's admission to the hospital. Further evidence in favor of this hypothesis arises from the fact that xanthosis cutis may be present several days before admission to the hospital. It is maintained, although no absolute proof was found, that the cause of xanthosis cutis in patients with poliomyelitis is carotene. The observation that the palms of normal healthy persons and the palms of patients with an acute infection, other than acute poliomyelitis or encephalitis, produce a fluorescence of a normal dusky-blue color, while the palms of patients with acute poliomyelitis and encephalitis complicating other acute infections produce a fluorescence of a yellow-green color, proved a new useful bedside aid to the diagnosis of poliomyelitis and particularly to the differential diagnosis between tuberculous meningitis and poliomyelitis.

Mites in Industry. B. H. Booth and R. W. Jones. A. M. A. Arch. Dermat. & Syph. **69**:531-542 (May) 1954 [Chicago].

During the investigation of a grain itch epidemic, which involved over 2,000 persons, Booth and Jones observed some aspects of mite-induced dermatoses. Dermatitis caused by the bite of the rat mite, Bdellonyssus bacoti Hirst, is not limited to one occupation. Persons working in groceries, markets, and restaurants seem to be most frequently attacked. The primary lesions are either wheals or vesicles, or both. Fowl mite dermatitis frequently appears as "small red bumps" or "itching hives" in persons who tend chickens or other poultry. The commonest occupational mite dermatosis in this country is probably that caused by chiggers, or trombidiosis. Three species of the more than 300 trombiculid mites described and classified are responsible for the majority of cases. Eutrombicula alfreddugesi and Eutrombicula masoni have a fairly wide distribution throughout most of the country. Eutrombicula batatas is restricted chiefly to southeastern United States. Farmers, harvesters, hunters, and berry pickers are exposed most frequently. Varieties of Sarcoptes scabiei that are responsible for scabies of man and transferable to man from animals are listed. Grain itch and acarodermatitis urticarioides are the terms most frequently used to designate the eruption caused by the attack of Pyemotes (Pediculoides) ventricosus. This mite parasitizes many insects, but its chief hosts are the Angoumois grain moth (Sitotroga cerealella Olivier) and the wheat jointworm (Harmolita tritici Fitch). The life cycle of P. ventricosus is explained. Away from the farm, grain itch may occur wherever straw is employed. Workers in strawboard factories were repeatedly attacked by mites during the 1950 and 1951 harvest seasons as infested straw was acquired and to a lesser extent in the spring and early summer as straw was removed from stock. Despite the discomfort, only three persons in three factories missed work as a result of grain itch. There was, however, general unrest. Grain itch can be prevented by means of insect repellents. During the last several years, new repellents and toxicants for insects have been developed that give effective protection against a number of insects, including chiggers.

UROLOGY

Osteomyelitis of the Spine from Urinary Infections. R. D. Mussey. Illinois M. J. **105**:253-256 (May) 1954 [Chicago].

Pyogenic osteomyelitis of the spine is rarely secondary to urinary tract infection; only 11 cases were collected from the literature, including the 2 cases reported here. Instrumentation or surgery of the lower urinary tract in men beyond the age of 45 usually precedes the osteomyelitis. If backache appears immediately or within a few weeks after an intervention on the lower urinary tract in middle-aged or older men, the surgeon should consider the possibility of a complicating pyogenic osteomyelitis of the spine. This is especially true if a urinary infection was present. The backache may be severe or mild and nagging. The clinical picture may be one of severe sepsis or a chronic, low grade infection. Paralytic ileus is commonly present if the pain is in the lumbar area. Should this complication be suspected, treatment should be started before a positive diagnosis can be made roentgenologically. Proper antibiotic or chemotherapeutic agents can be selected after the probable organism is isolated from the urine by culture. Adequate immobilization is important as well as general supportive measures. It is assumed that the infection probably spreads from the urinary tract to the vertebral column by the vertebral system of veins.

Conservative Management of Acute Renal Insufficiency. E. D. Hendricks and L. F. Greene. Proc. Staff Meet., Mayo Clin. **29**:205-210 (April 21) 1954 [Rochester, Minn.].

Acute renal insufficiency may be secondary to shock, intravascular hemolysis, severe trauma, or the absorption of renal toxins. The clinical picture is similar and the renal insufficiency is potentially reversible. Tubular regeneration usually produces a return of excretory function within 10 to 12 days. The artificial kidney, while extremely valuable, is not generally available because of its expense and the skilled personnel required for its operation. Conservative medical management designed to prevent or correct imbalances that occur in acute renal insufficiency can produce excellent results. The treatment of acute renal insufficiency may be divided into (1) the initial phase, (2) the anuric or oliguric phase, and (3) the diuretic phase. During the initial phase, it is essential to correct the shock, eliminate postrenal obstruction, dispense with any medication likely to become cumulative, and insert an indwelling urethral catheter. The anuric or oliguric phase calls for (1) maintenance of fluid balance by restriction of total fluids to the calculated insensible loss, plus the measured fluid loss in urine, feces, vomitus, and drainage; (2) reduction of protein catabolism with a high caloric, protein-free dietary regimen, providing at least 2,000 calories daily; and (3) correction of acidosis with intravenous sodium lactate or sodium bicarbonate, of potassium intoxication with cation-exchange resins and glucose-insulin injections, and of tetany with intravenous calcium preparations. During the third or diuretic phase, it is essential to insure adequate replacement of the large amounts of water and electrolytes excreted.

Tumour of the Urinary Bladder as an Occupational Disease in the Rubber Industry in England and Wales. R. A. M. Case and M. E. Hosker. Brit. J. Prev. Soc. Med. **8**:39-50 (April) 1954 [London, England].

During investigations incidental to a survey of occupational tumors of the urinary bladder in men in the British chemical industry, it was found that men engaged in the manufacture of a certain rubber antioxidant of the primary aromatic amine class had suffered heavy casualties from bladder tumors. The antioxidant, which was a formaldehyde condensation product of alpha-naphthylamine and beta-naphthylamine, contained a small proportion (about 2.5%) of uncombined naphthylamines, and pilot experiments showed that quantities of naphthylamines were vaporized during the processing of a rubber "mix." In addition, the condensation process also led to the formation of 1:2:8:9-dibenzacridine. This substance has been isolated from the antioxidant, and a highly purified synthetic specimen has been shown to be carcinogenic when injected into mice. Studies were made to ascertain (1) whether there is an increased risk of tumor of the bladder in workmen engaged in rubber occupations compared with the total male population of England and Wales; (2) whether this risk persists in areas where the particular antioxidant under consideration is known to have been used; (3) whether the risk shows a change with 1935-1936 as a pivotal point. In the concluding summary the authors stress the following points. 1. There seems to be reasonably good statistical evidence for saying that, in the period between 1936 and 1951, an occupational risk of dying of bladder tumor can be demonstrated among men in England and Wales who are employed in rubber industries. 2. There is even better statistical evidence for saying that in a borough that is an important center of the rubber industry there is an occupational risk of contracting bladder tumor among men so employed. This evidence covers the years 1936-1950. 3. There is no statistical evidence even to suggest that such an occupational risk of dying of bladder tumor was operating among men in these occupations in England and Wales in the period 1921-1935. 4. These findings are consistent with, but do not prove, the hypothesis that the risk was introduced into the industry with the aforementioned antioxidant in 1928. 5. When the trend of these studies became known, the manufacture of the antioxidant was ceased and the rubber industry discontinued its use. 6. Cases of bladder tumor have also been noted in fitters, engineers, and others in ancillary jobs in the rubber industry who might be expected to have intermittent contact with the antioxidant through contaminated machinery. No statistical data are available to permit an opinion about the possible occupational origin of these cases.

Role of the Urine in Vesical Neoplasm: 1. Experimental Confirmation of the Urogenous Theory of Pathogenesis. D. F. McDonald and R. R. Lund. J. Urol. **71**:560-570 (May) 1954 [Baltimore].

The experiments described aimed to find answers to two questions. 1. Do the urinary constituents play an important part in producing experimental bladder tumors? 2. Will estab-

lished experimental tumors regress when deprived of contact with urine? In 10 young adult female mongrel dogs and 29 adult male rabbits, the dome half of the urinary bladder was surgically transformed into a pouch isolated from contact with the urine. In all cases care was taken to preserve the blood supply to the pouch. The animals received the carcinogen beta-naphthylamine orally. Capsules containing 600 mg. were given daily to the dogs. A 0.1% solution of beta-naphthylamine hydrochloride was given ad libitum to the rabbits in place of drinking water. The daily voluntary intake averaged 350 mg. Cystoscopy was performed at monthly intervals. It was found that bladder tumors can be induced in dogs by beta-naphthylamine. Rabbits were resistant to induction of beta-naphthylamine tumors in the dosage and time selected, but it was found that hyperplasia and metaplasia may result. Epithelial contact with the urine was essential for the production of experimental bladder tumors in dogs. This confirms the urogenous theory of vesical carcinogenesis. Deviation of the urine from established experimental bladder tumors did not inhibit their growth. Renal adenoma and early transitional cell carcinoma of the collecting duct epithelium could be induced by beta-naphthylamine. The experiments show that urinary constituents have a causative role in the production of beta-naphthylamine bladder tumors in dogs. In no case did carcinoma develop in epithelium not in contact with urine. If a blood borne carcinogen were responsible for tumor growth, then neoplastic change should have developed in the bladder epithelium in the pouch with an intact blood supply. Neoplastic change occurring in pouches communicating with the bladder and hence containing urine demonstrated that the pouch epithelium was just as susceptible as the bladder epithelium when properly stimulated. The active urinary carcinogen was not identified in this study, but the work of other investigators indicates that it is present in both blood and urine. The fact that hyperemia and telangiectasis were the first lesions noted on cystoscopy does not necessarily indicate a hematogenous route; rather it may indicate that the urine borne carcinogen is acting as an irritant with resulting hyperemia.

THERAPEUTICS

A Dangerous Universal Donor: Acute Renal Failure Following Transfusion of Group O Blood. A. R. Stevens Jr. and C. A. Finch. Am. J. Clin. Path. **24**:612-620 (May) 1954 [Baltimore].

Stevens and Finch present the case of a man, aged 39, who was participating in a study of red blood cell survival. He was of blood group A and was given a transfusion of type O blood that had been stored for four weeks. During the first 30 minutes, 200 ml. of blood was given. At this time his face appeared flushed. After 55 minutes, approximately 350 ml. of blood had been given. He then began to have a chill, and the transfusion was discontinued. Two hours after the reaction, he passed a small amount of dark brown turbid urine containing many coarsely granular casts of large caliber, as well as protein. Free hemoglobin was present in the blood and in the urine. The urinary output during the first 24 hours was 390 ml. The serum was red immediately after the reaction. The patient was allowed to return home. He experienced no symptoms other than fatigue during the next two days. The urinary output, however, remained about 400 ml. daily, and the sediment contained numerous casts and albumin. The patient was hospitalized and placed on bed rest with a diet low in protein, sodium, and potassium. Despite a restriction in fluid intake to 1,500 ml. daily, there was increase in extracellular fluids as evidenced by slight pretibial edema. Diuresis began on the seventh day with loss in weight and reduction in blood urea nitrogen. Dietary potassium was increased at this time, and the man was allowed to take water at will. The urine specific gravity remained fixed for three weeks. The urinary sediment continued to show cells and granular casts for a two month period in decreasing quantity. By the third month, however, the sediment appeared normal and no protein was demonstrable in the urine. The case met the clinical and laboratory criteria of an incompatible transfusion reaction. It was shown that the recipient's rather than the donor's erythrocytes were destroyed and that a potent anti-A hemolysin was present in the plasma of the donor. The mild dehydration of the recipient, the preceding phlebotomy of 500 ml., the rigor and febrile reaction, and the intravascular hemolysis may have contributed to the development of the renal lesion. This reaction illustrates the potential hazard in the transfusion of group O blood to a recipient of another blood group. It is suggested that group O persons having a history of horse serum injection within the past year be rejected as "universal donors."

Thrombopenic Purpura: Response to ACTH. S. Erdstein and S. Iriarte. Rev. Asoc. méd. argent. **68**:27-28 (Jan.-Feb.) 1954 (In Spanish) [Buenos Aires, Argentina].

A woman, 62 years old, complained of subcutaneous hemorrhages that for the last five years recurred at intervals of a few weeks, persisted for about one month, and disappeared. Twice within an interval of three months she had copious hemorrhages that lasted for 12 and 24 hours, respectively, after extraction of a tooth. The second hemorrhage was followed immediately by copious hemorrhages on the neck and the left side of the face and by conjunctival, buccopharyngeal, and diffuse subcutaneous hemorrhages, which were copious in the gluteal regions, the thighs, and forearms. Melena occurred every two or three hours for 12 days. The general condition of the patient was grave. The symptoms were typical of thrombopenic purpura. The number of platelets was greatly diminished, the bleeding time was prolonged, and the fragility of the capillaries greatly increased. Penicillin, vitamins K and C, folic acid, and a transfusion of 250 cc. of blood failed. The treatment consisted of intramuscular injections of corticotropin (ACTH) in doses of 25 mg. every 4 hours for two days, every 6 hours for one day, and every 8 and 12 hours in alternation for two days, up to a total dose of 600 I. U. The results were spectacular. The hemorrhagic tendency immediately disappeared, coincidentally with rapid return to normal of the bleeding time and of the capillary resistance. The number of platelets slowly increased for six months from 21,800 per cubic centimeter of blood before the treatment to 139,000 per cubic centimeter of blood six months after discontinuation of the treatment. Convalescence followed a rapid course to recovery that had persisted up to six months after discontinuation of treatment. The authors believe that thrombopenic purpura is due to a disorder of the suprarenal cortex with production of a toxic agent that damages the platelet-forming segment of the hematopoietic system and the wall of the capillaries. Corticotropin effects permanent control of the suprarenal disorder with immediate return to normal of the capillary resistance and of the bleeding time. Its use is indicated in seriously ill patients with thrombopenic purpura when (1) splenectomy is not indicated, (2) preparing acutely ill patients for splenectomy and (3) treating acute recurrences of the disease in patients who have had splenectomy.

Experimental Chemotherapy of Tumors. G. Domagk, S. Petersen and W. Gauss. Ztschr. Krebsforsch. **59**:617-622 (No. 6) 1954 (In German) [Berlin and Munich, Germany].

Domagk and associates point out that experimental research on cancer has been somewhat disappointing insofar as no chemotherapeutic substance has been found that can be used in several types of tumors, particularly in true carcinomas. Urethan (ethyl carbamate) proved effective in certain forms of leukemia, and the same can be said about some nitrogen mustards and triethylene melamine (TEM). In experiments carried out by Hackmann, actinomycin proved effective against the Walker carcinoma of the rat, and clinically actinomycin proved most effective against Hodgkin's disease. These and other observations prove that the different chemotherapeutic substances will be effective in certain types of tumors. For some time American investigators have tested therapeutic substances in a variety of neoplasms. Domagk and co-workers tested compounds that were potent bacteriostatics against tumors. Since quinone derivatives had proved effective against streptococcic and enterococcic infections, they tested these compounds in experimental tumors, the more so since others found them effective as radiosensitizers in irradiation therapy of malignant

tumors. At first, the quinone derivatives exerted a relatively weak effect on tumors, but it was found that potent cytostatic effects could be produced by combining ethylenimine and its derivatives with quinones, the ethylenimine group having potent tumor-inhibiting effects. By combining benzoquinone-1,4 with 2 moles of ethylenimine, they obtained 2.5-bis-ethyleniminobenzoquinone-1,4. This compound had a potent effect on Yoshida tumors in rats. In further experiments, the authors compared this compound with nitrogen mustard and triethylene melamine. The quinone combined with ethylenimine groups proved more effective in Yoshida sarcoma than either of these two substances. It also proved more effective in Ehrlich carcinoma than nitrogen mustard. The new quinone with ethylenimine proved less toxic than either nitrogen mustard or triethylene melamine.

PATHOLOGY

Primary Tumors of the Heart in Infancy and Early Childhood. N. H. Bigelow, S. Klinger and A. W. Wright. Cancer **7**:549-563 (May) 1954 [Philadelphia].

Although primary tumors of the heart are rare, the fibroma and the muscle abnormalities sometimes referred to as a rhabdomyoma are the two types of primary tumors of the heart that occur disproportionately often in infancy and childhood. The gross and microscopic features of these two groups of lesions, often indiscriminately called rhabdomyomas, are quite distinct and characteristic, although their probable identity as a specific type of neoplasm has not previously been clearly recognized and a large number of terms, some of them contradictory, have been employed to designate them. Two cases of cardiac tumors that illustrate these two different types of growths are reported. A "primitive fibroma" or "fibromyoma" was observed in a full-term baby girl who died on the third day after delivery. The heart was greatly enlarged and in the lateral wall of the left ventricular myocardium there was a solitary, circumscribed but nonencapsulated, oval, gray-white mass, measuring 5 by 3 by 2.5 cm. Microscopically, the cardiac tumor was composed of interlacing and anastomosing cords or bands of tissue in which wavy fibrils of collagen formed a predominant feature but in which also fairly thick hyaline strands, which may have represented primitive muscle fibers, were present. The cells appeared to be of two main types, the majority being spindle-shaped with small amounts of pale, faintly granular cytoplasm, having the morphology and staining characteristics of fibroblasts. The nuclei were oval and vesicular and tended to be hypochromatic. The cytoplasm of the cells of the second type was more abundant and contained delicate fibrils with cross striations that could be seen most distinctly in preparations stained with phosphotungstic acid and hematoxylin. These two types of cells were supported by small amounts of fibrous stroma in which were numerous thin-walled blood vessels. The other type of tumor, for which the term "congenital rhabdomyomatosis of the heart" seems to be the least unsatisfactory designation, was observed in a 3-month-old premature baby girl who was operated on for an acute abdominal condition and who died within five hours after the laparotomy. Necropsy revealed numerous round or oval circumscribed opalescent nodules, measuring from 0.1 to 0.6 cm. in diameter, throughout the myocardium, most prominently in the left ventricle. Microscopic examination of these lesions showed them to be sharply circumscribed nodules of markedly vacuolated and distended cardiac muscle fibers with coarsely reticulated cytoplasm in which cross striations were readily visible. Some foci were minute and consisted of three or four cells, while others were large and consisted of 100 or more cells. In a few situations, only a single isolated cell exhibited this abnormality. Several large nuclei, present within cytoplasmic vacuoles, were connected by protoplasmic bands to the surrounding cytoplasm. These were the "spider cells" that are so characteristic of these lesions. Although the reported morphological characteristics are unique and unequivocal, their interpretation and evaluation are still unsettled. Reports of primary malignant tumors in infancy and early childhood are uncommon, but, of the few cases reported, only one, that of a malignant teratoma, is considered fully acceptable, while one case of fibrosarcoma may possibly have originated in the heart.

Widespread Acute Necrosis of Liver Following Sulfonamide Therapy in Patients with Leukemia. K. V. Lodge and A. S. Woodcock. Am. J. Path. **30**:361-372 (March-April) 1954 [Ann Arbor, Mich.].

Hepatic necrosis, either focal or massive, is recognized as an infrequent complication of sulfonamide therapy. Lodge and Woodcock recently noted extensive acute hepatic necrosis at necropsy in three patients with leukemia. Inquiry revealed that all three had received sulfonamides shortly before death, and the authors feel that this played a part in the production of the necrosis. They were unable to find any report of hepatic necrosis as a complication of leukemia itself. Livers of 97 other patients with leukemia revealed no necrosis. From their own cases and from literature, the authors gained the impression that hepatic necrosis after sulfonamide therapy is of allergic origin. In leukemia there seems to be unusual danger of this complication, particularly if sulfonamides are given in repeated courses. Penicillin or some other antibiotic might be preferable for treating intercurrent infections in leukemia.

Recognition of Talc Granuloma. A. Stacher. Wien. klin. Wchnschr. **66**:313-316 (May 7) 1954 (In German) [Vienna, Austria].

Stacher reports 25 cases of talc granuloma observed among the operative specimens that were studied in the course of seven years at the anatomicopathological department of the Hospital of the Vienna Insurance Fund for Workers and Employees. There were 15 genuine talc granulomas requiring secondary operations, 7 were combined talc and suture granulomas, and 3 represented tissue reactions to talc inclusions that were detected on secondary operations performed for other reasons. The size of these granulomas varied from that of a lentil to that of a fist. They were removed by excision within 2 months to 14 years after the performance of an operation or the occurrence of an injury. Various erroneous clinical diagnoses had been made before the excision of these granulomas. Double refraction, being considered as characteristic of talc in microscopic sections, was also observed in 36 additional operative specimens in which it was associated with other foreign body inclusions originating from suture material. Various common staining methods were tested for differentiation and for demonstration of talc. A modification of Feigl's method of spot reaction to silicates was devised by which light to dark blue discoloration of the filter paper was produced depending on the amount of talc contained in the section. This reaction, which proved to be simple and reliable, is elicited by the formation of the complex silicomolybdenic acid from ammonium molybdate with alkali silicates. The silicomolybdenic acid is heated, oxidizes the benzidine to benzidine blue, and is simultaneously reduced itself to molybdenic blue. The problem of an adequate nonirritating substitute for talc, when applied in the medical field, has not been solved, but its importance for the physician and the patient deserves to be stressed, since the high incidence and severity of the damage caused by the talc have not yet been sufficiently recognized.

RADIOLOGY

Fission Product Caesium ^{137} for Use in Telecurie Units. W. S. Eastwood. J. Fac. Radiologists **5**:282-285 (April) 1954 [Bristol, England].

Caesium 137 is a long-lived (33 years half-life) fission product. Its application to therapy was proposed independently by workers at Oak Ridge and Harwell. Caesium 137 is formed as a fission product resulting usually from the splitting of fissile uranium 235 under neutron bombardment. From data available a typical source for a telecurie unit might be 7,000 curies of caesium salt in the shape of a right cylinder 5 cm. diameter and 5 cm. long. This would give about 20 r per minute at 1 meter in air. Since cobalt 60 units are already in operation, a compari-

son between caesium and cobalt may be made. Cs^{137} is the main long-lived gamma emitter in fission wastes. Its extraction for useful purposes is a help to those concerned with methods of active effluent disposal. Caesium is furthermore inexorably forming in every pile and will soon be plentiful. The cost should, therefore, depend not on the neutron absorption, as with cobalt, but on the extraction and processing plant costs. A caesium source once installed should require no further attention for 10 to 15 years. This must be contrasted with cobalt resources, which may need replenishment every two to three years. Only clinical trial can show whether there are differences between treatment by gamma energies of 0.66 mev. and 1.2 mev. Experience with iridium therapy of comparable energy with caesium has been satisfactory. With caesium the lead shield is both smaller and lighter than with cobalt. Not only is this a saving in cost of lead, but a lighter treatment head makes for greater flexibility in the case of rotational and arc therapy. Size of source would appear to be the only serious drawback with caesium. A source to give 20 r per minute at 1 meter will be about twice the diameter of the equivalent cobalt source. The first 1,000 curie source of caesium is now being assembled and tested by the Oak Ridge medical division.

Cobalt 60 Beam Therapy. A. M. Evans, R. G. Moffat, R. D. Nash and others. J. Fac. Radiologists **5**:248-260 (April) 1954 [Bristol, England].

The authors discuss technical details and opinions concerning a cobalt 60 beam therapy apparatus, which has been in operation since October, 1952. Conclusions concerning the treatment are preliminary. Eighty-four patients with malignant disease were treated. The longest follow-up was six months. Many of the lesions were advanced and would have responded poorly to any form of treatment. One patient is presumed to have a myelitis of the cord in the midthoracic region, which was produced by treating a medial lung tumor through anterior and posterior fields. The dose to the cord was 5,000 r in 35 days. With the techniques used to date, there has been more edema of laryngeal structures than with medium voltage x-rays. Bone and cartilage necrosis and damage to subcutaneous tissue and other organs may appear. Generally speaking, patients tolerated curative treatment better, and it is possible to give palliative treatment with less disturbance to the patient and with greater ease in treatment set-up than with 200 or 400 kv. x-ray therapy. The response of tumors of the head and neck has been better than with medium voltage x-rays, because it is possible to deliver a higher tumor dose with less risk of bone or cartilage damage, fewer skin effects, and disturbance to the patient. Inoperable metastases in lymph nodes regressed satisfactorily. High tumor doses can be applied to the breast and metastatic areas in five to six weeks without untoward skin or constitutional reaction. The pelvis appears to tolerate doses of 5,000 r in five weeks, and this seems to be a suitable treatment for uterine cancer, including cervical stump, unsuitable for local radium treatment; carcinoma of the ovary where the disease is limited to the pelvis; cancer of the bladder; cancer of the prostate; and cancer of the rectum. Soft tissue sarcomas, malignant melanoma, and parotid growths show a more satisfactory regression than with medium voltage x-rays. A cobalt source used at a shorter distance would be more advantageous.

Our Experiences with Percutaneous Lumbar Aortography. A. Temesvári and S. Jóna. Schweiz. med. Wchnschr. **84**:564-566 (May 15) 1954 (In German) [Basel, Switzerland].

Roentgenographic visualization of the abdominal aorta and its branches at that instant when they have been rendered radiopaque by the injection into the aorta of 70% Ioduron (morpholine salt of diiodized pyridone) according to Dos Santos' technique of direct puncture of the aorta was obtained with the aid of local anesthesia (20 to 30 cc. of a 0.25% solution of procaine hydrochloride) in 40 patients admitted to the surgical department of the University of Budapest, Hungary. Of the 40 patients, 20 had endarteritis obliterans, 16 had atherosclerosis, and 4 were suspected of having aneurysm or underwent control examinations after being operated on for aneurysm. Complications and undesirable side-effects such as vertigo, nausea, dyspnea, or urticaria were not observed. A hematoma occurred in one patient in whom the needle moved out of the aorta in the course of the aortography; this patient had for several hours mild pain in the abdomen and back, but a control examination performed 24 hours later showed that the contrast medium outside the aorta had disappeared. All patients had a sensation of heat in their lower extremities after the aortogram was taken. Patients with high-seated obliteration experienced this sensation of heat in only one of the lower extremities. Ioduron proved to be an excellent contrast medium that, even in the pregangrenous state, did not cause deterioration of the circulation, but on the contrary caused improvement in some cases. Aortography offered considerable aid in the diagnosis of selected cases.

Intracerebral Arteriovenous Malformations: Their Diagnosis and Angiographic Demonstration. W. G. Scott, W. A. Simril and W. B. Seaman. Am. J. Roentgenol. **71**:762-776 (May) 1954 [Springfield, Ill.].

The authors report on 22 patients with intracerebral arteriovenous malformations. There were 17 with arterial angiomas and arteriovenous connections situated within the brain. Five patients presented carotid-cavernous fistulas located at the base of the brain. Of the 17 patients with angiomatous arteriovenous malformations, 10 were adults and 7 were children, 2 were less than 1 year old, 1 was 6 years old, one was 8 years old, two were 9 years old, and one was 13 years old. The five patients with carotid-cavernous fistulas were adults. The diagnosis of the arteriovenous malformations was determined from a study of the symptoms and physical findings and of the cerebral angiograms. Of the 17 patients with angiomatous arteriovenous malformations, those old enough to relate their complaints had headache, sudden in onset and progressive in severity. There were episodes of unconsciousness and periods of coma in 11, and these could be correlated with subarachnoid or intracortical hemorrhages in 9. Epileptiform seizures appeared in six patients and were a manifestation of irritation or minor hemorrhages from vessels that are prone to involve the paracentral convolutions. Nausea and vomiting occurred in eight patients and were always associated with intracranial hemorrhages. An audible bruit could be heard in five, and intracranial calcifications were detected in four. A bruit apparent to both the patient and the examiner, pain behind the eye, diplopia, photophobia, and a pulsating exophthalmos were present in all five patients with carotid-cavernous fistulas. The symptoms in both groups of patients depended on the number and size of the vessels and the segment of the brain involved and whether the arteriovenous malformations resulted in episodes of subarachnoid or intracerebral hemorrhage. Cerebral angiography, indispensable for the comprehensive understanding of the location, size, extent, arrangement, and vascular connections of intracerebral arteriovenous malformations, was satisfactorily performed with conventional roentgenographic equipment and involved only a minor risk. Biplane angiographic units utilizing roll film cassettes afforded the desirable advantage of obtaining lateral and anteroposterior views after a single injection of 7 to 10 cc. of 30% sodium acetrizoate (Urokon sodium). Treatment of arteriovenous malformations is surgical extirpation whenever feasible. It was performed in 3 of the 17 patients with angiomas with arteriovenous communications. The criteria for surgical intervention were based on the comprehensive angiographic visualization of the vascular malformation, on its location within the brain, and on a careful evaluation of the neurological damage that may result from the surgical effort as compared to the severity of the symptoms and the ultimate prognosis. The results from ligation of the main feeding arteries or of the internal carotid artery in 5 of the 17 patients with angiomas were disappointing. If surgical measures are not advisable for the patients with this type of lesion, roentgen irradiation therapy may be used if the lesion is superficial and localized to a small area, although the results are usually indefinite. In the group with carotid-cavernous sinus fistulas, ligation of the internal carotid artery was an effective measure. Intracerebral arteriovenous malformations are a more frequent cause of intracranial disorders than was formerly believed. Their detection is important, as their diagnosis can now be readily established and operative techniques are available for the successful extirpation of many of them.

BOOK REVIEWS

How to Help Older People: A Guide for You and Your Family. By Julietta K. Arthur. With introduction by Wilma Donahue, Ph.D., Chairman, Division of Gerontology, Institute for Human Adjustment, University of Michigan, Ann Arbor. Cloth. $4.95. Pp. 500. J. B. Lippincott Company, 227-231 S. Sixth St., Philadelphia 5, 1954.

The publication of an increasing number of books concerned with older persons is an indication of the rapid increase in interest in their problems. Here is still another volume of the "how to help" series that is offered as a guide to a healthier and happier existence for the older person and his family. It is presented in easy and readable style. The table of contents emphasizes the values of normal old age and points out that aging is not a disease. Although the book is wordy and somewhat padded and includes a great deal of material that has been well covered in other books, the case discussions and illustrations are well selected and make their points with conviction. The problems of financing old age, homes for the well, and community care for the sick are handled in a resourceful manner. Certainly one of the most troublesome vexations is the question of active leisure; this book discusses a number of attractive activities that are appropriate and should prove satisfying for many senior citizens. The "Forty Plus" clubs for social and hobby activities are discussed. Ways and means of organizing clubs for recreational pursuits are dealt with admirably.

One of the unhappy circumstances of the present aging population is their lack of preparation for the years that are being added by the "magic" of medical science. Society must explore outlets that might furnish older persons with employment that is profitable and at the same time is satisfying in maintaining personal independence and dignity. At present, too many persons approaching the later years have given little thought to the period of life that should be a time of enjoyment and fulfillment. The book concludes with chapters on what to do with the mentally ill and what is new for the old. The appendixes are excellent and furnish valuable information bearing on special problems of older persons. This book may well be recommended to the medical profession, which must open its eyes to the growing problems of the elderly, and to the public, which must foot the bill.

A Formulary for External Therapy of the Skin. By Chester N. Frazier, M.D., Dr.P.H., Edward Wigglesworth Professor of Dermatology, Harvard Medical School, Boston, and Irvin H. Blank, Ph.D., Research Associate in Dermatology, Harvard Medical School. Publication number 201, American Lecture Series, monograph in Bannerstone Division of American Lectures in Dermatology. Edited by Arthur C. Curtis, M.D., Chairman, Department of Dermatology and Syphilology, University of Michigan, Ann Arbor. Cloth. $3.25. Pp. 118, with 11 illustrations. Charles C Thomas, Publisher, 301-327 E. Lawrence Ave., Springfield, Ill.; Blackwell Scientific Publications, Ltd., 49 Broad St., Oxford, England; Ryerson Press, 299 Queen St., W., Toronto 2B, 1954.

This excellent monograph was prepared originally to fill the requirements of the Massachusetts General Hospital. It provides a rational and logical approach to external therapy and is free from the trivialities so common to specialized branches of medicine. The objectives of superficial dermatological therapy are practically limited to the palliative relief of symptoms. The measures to be taken to assist nature in restoring the skin to health when it is diseased are few, and this formulary has the required brevity rather than an encyclopedic scope. It also emphasizes that external therapy is only a part of the treatment of a diseased skin. The preliminary chapters discuss the evolution of the formulary, the objectives of external therapy, the basic principles of treatment, and measures of value for the proper cleansing of the skin. Subsequent chapters are devoted to ointment vehicles, emollients and protectives, antipruritics, anti-infectives, antieczematous and antiseborrheic agents, and antiperspirants. This formulary purposely omits discussion of many common medicaments and treatments, because proof of their therapeutic efficiency is inadequate; to make a formulary inclusive would require unnecessary elaboration. The bibliography is small, but the references are well chosen. The illustrations are few but of excellent quality.

These book reviews have been prepared by competent authorities but do not represent the opinions of any official bodies unless specifically so stated.

A Ciba Foundation Symposium: Peripheral Circulation in Man. Editors for Ciba Foundation: G. E. W. Wolstenholme, O.B.E., M.A., M.B., and Jessie S. Freeman, M.B., B.S., D.P.H. Assisted by Joan Etherington. Cloth. $6. Pp. 219, with 72 illustrations. Little, Brown & Company, 34 Beacon St., Boston 6, 1954.

This volume consists of material presented and discussed during a three day symposium on the peripheral circulation in man. The papers have been well presented, and the discussion is free and critical. In view of the distinguished list of participants, this technique of formulation places at the reader's disposal a large background of experience and knowledge. Following papers based on some current experimental techniques, the matter broadens to include such fields as the production and action of epinephrine and arterenol (Nor-Adrenaline), reactions of blood flow to temperature changes, and numerous facets of the complex relationship of blood vessels to their innervation. Anatomic and pathological studies and discussions regarding the effectiveness of sympathectomy are also included. It was concluded that no single method of measuring blood is without artefact; that many details regarding the significance and physiological responses of arteriovenous anastomoses, whether anatomic or functional, have yet to be elucidated; and that this problem has suggested the wisdom of deferring final interpretation of much of the work already done on total blood flow until these details have been more completely resolved. The increased attention now devoted to the importance of vasodilator fibers in the sympathetic outflow and the enhanced response of the vessel after sympathectomy to epinephrine and arterenol reinforce former doubts as to the efficacy of sympathectomy in the treatment of peripheral vascular disease. Although this volume is directed primarily to those who are working in the field of peripheral circulation or are especially interested in it, all students of medicine should find it stimulating.

A Synopsis of Anesthesia. By J. Alfred Lee, M.R.C.S., L.R.C.P., M.M.S.A. Third edition. Cloth. $3.50. Pp. 483, with 72 illustrations. Williams & Wilkins Company, Mount Royal and Guilford Aves., Baltimore 2; [John Wright & Sons, Ltd., 42-44, Triangle West, Bristol 8, England], 1953.

This edition of Lee's book (previous editions appeared in 1947 and 1950) touches briefly on most aspects of anesthesiology. The slight increase in the size of this edition is due to alterations and revisions as well as to additional chapters dealing with postoperative medication, production of ischemia during operations, therapeutic aspects of anesthesia, and postoperative recovery rooms. It is well written and contains a limited number of references. The appendix contains various conversion tables and biochemical values. An adequate index is included. Several of the illustrations and some of the discussions pertaining to apparatus are particularly concerned with British equipment and may be somewhat confusing to the undergraduate medical student or beginning anesthesiologist in the United States. Several of the author's beliefs differ from those currently held in the United States, for instance, those concerning the correct method of administration of open drop ether and the use of ethylene. The author is to be complimented on the preparation of this useful book, which is presented in a handy size, attractive binding, and good type. Since it contains a good summary of current teaching and practice, it will be particularly useful to those preparing for examination. It can be recommended to medical students, residents in anesthesiology, and medical practitioners.

Handbook of Tropical Dermatology and Medical Mycology. Volume II. Edited by R. D. G. Ph. Simons, Dermatologist in charge at Civilian Hospital, Amsterdam. Cloth. $15. Pp. 851-1705, with 511 illustrations. Elsevier Press, Inc., 402 Lovett Blvd., Houston 6; 155 E. 82nd St., New York 28; 118 Spuistraat, Amsterdam C, Netherlands, 1953.

This 4-pound handbook contains a wealth of information. It covers the subjects of tumors and diseases due to animal parasites, fungi, metabolic disturbances, allergy, and malnutrition. As did volume I, it succeeds in attaining a measure of completeness seldom achieved in a single work. It includes brief descriptions of exceedingly rare diseases, although most of the book is devoted to the commoner diseases. The section on diseases due to fungi is exceptionally good, occupies more than half the book, and covers all phases of the subject—history, physiology, allergy, experimental infections, clinical manifestations, therapy, cultural characteristics, etc., of superficial and deep mycotic infections. The section on diseases due to animal parasites is also complete, with descriptions of both familiar and bizarre eruptions, and even includes a chapter on insect repellents and toxicants. Benign and malignant tumors, allergy, the related id concept, drug eruptions, and deficiency syndromes are all discussed authoritatively. Since 58 authors contributed to this volume, the pace is uneven in places, but by and large the editor has managed to attain a high degree of uniformity in the presentations. There is a glossary of current clinical and pathological dermatological terms. All of the chapters contain pertinent references, the book is fully indexed and the numerous illustrations in black and white are well selected and of good quality. This volume maintains the high standard of the first volume in all respects.

The Megaloblastic Anaemias. By L. J. Davis, M.D., F.R.C.P., F.R.C.P.E., Muirhead Professor of Medicine in University of Glasgow, Glasgow, Scotland, and Alexander Brown, M.D., F.R.C.P.E., F.R.F.P.S.G., Assistant Physician, Royal Infirmary, Glasgow. Publication number 222. American Lecture Series, monograph in American Lectures in Internal Medicine, edited by Roscoe L. Pullen, A.D., M.D., F.A.C.P., Professor of Medicine and Dean, University of Missouri School of Medicine, Columbia. Cloth. $4.50. Pp. 113, with 12 illustrations. Charles C Thomas, Publisher, 301-327 E Lawrence Ave., Springfield, Ill.; Blackwell Scientific Publications, Ltd., 49 Broad St., Oxford, England; Ryerson Press, 299 Queen St., W., Toronto 2B, 1953.

In very few fields of medicine has such dramatic progress been made in recent decades as in the treatment of megaloblastic anemias. Prior to Minot and Murphy's discovery of the therapeutic value of liver in pernicious anemia, this disease was indeed pernicious. The availability of specific therapy emphasizes the importance of correct diagnosis of the megaloblastic anemias. The emphasis on diagnosis and the fact that this book is addressed mainly to the general practitioner are its most important features. The six chapters deal with the concept of megaloblastosis, therapeutic preparations, Addisonian pernicious anemia, non-Addisonian megaloblastic anemia, diagnosis, and the etiology of the megaloblastic anemias. By careful and judicious selection of material the authors have presented an astounding amount of information in a small space. They have also succeeded in giving a lucid presentation of a subject that is in some aspects highly controversial. The references are well chosen. This book is highly recommended to both general practitioners and specialists.

Pharmacology and Therapeutics: A Textbook for Students and Practitioners of Medicine. By Arthur Grollman, Ph.D., M.D., F.A.C.P., Professor and Chairman of Department of Experimental Medicine, Southwestern Medical School, University of Texas, Dallas. Second edition. Cloth. $10. Pp. 866, with 127 illustrations. Lea & Febiger, 600 S. Washington Sq., Philadelphia 6, 1954.

In this edition, Grollman has retained the general plan of the first edition but has enlarged and revised the text to include the advances of the past three years in the field of pharmacology. Although this book replaces the revered Cushny's, little of the original material has been retained. The lucidity of Grollman's style and the breadth of treatment make this one of the most attractive and useful of the several medium-sized textbooks of pharmacology currently available. The physician should find it a useful reference, and the student should appreciate the organization of the text and the wealth of excellent illustrations.

Fundamentals of Neuropathology. By William Brooks Dublin, M.D., Chief, Laboratory Service, Veterans Administration Hospital; Fort Logan, Colorado. Cloth. $18.50. Pp. 685, with 329 illustrations. Charles C Thomas, Publisher, 301-327 E. Lawrence Ave., Springfield, Ill.; Blackwell Scientific Publications, Ltd., 49 Broad St., Oxford, England; Ryerson Press, 299 Queen St., W., Toronto, 2B, 1954.

The author, by reason of long experience, is well qualified to write on the fundamentals of neuropathology. The usual fields of disease and injury of the nervous system are adequately covered, with a long section on tumors. Illustrations of gross and microscopic preparations are usually adequate. The chief weakness of the book is in the handling of clinical material. Some descriptions of diseases are faulty or erroneous. Theoretical problems are poorly handled, and papers of secondary quality are frequently cited as references. In spite of sound descriptions of neuropathology, the book is not entirely satisfactory as a reference; its unevenness of quality precludes a full endorsement.

Entomology (Medical and Veterinary) Including Insecticides & Insect & Rat Control. By D. N. Roy, M.D., D.T.M., D.Sc., In-charge Department of Medical Entomology & Biology, Indian Institute for Medical Research, Calcutta, and A. W. A. Brown, M.B.E., Ph.D., Professor and Head of Department of Zoology, University of Western Ontario, London, Canada. Second edition. Cloth. 30 rupees. Pp. 413, with illustrations. Excelsior Press, 11A, Hidaram Banerjee Lane, Calcutta 12, 1954.

In the first part of this book descriptions of various insects are presented in a readable manner that makes identification easy. The author has also incorporated brief notes on the effect of insects on daily living. The second part of the book, prepared by Dr. Brown, was not included in the first edition. It presents the chemistry of insecticides, their mode of action, their application, and acquired resistance to them. Rodent control is discussed, and poisons to be used for rats and other rodents under various circumstances are described. The physician and the veterinarian should find this a valuable book.

Pharmacology. By J. H. Gaddum, Sc.D., F.R.S., M.R.C.S., Professor of Pharmacology in University of Edinburgh, Edinburgh, Scotland. Oxford medical publications. Fourth edition. Cloth. $8. Pp. 562, with 89 illustrations. Oxford University Press, 114 Fifth Ave., New York 11; Amen House, Warwick Sq., London, E.C.4, 1953.

This book, which first appeared in 1940, is designed to acquaint medical students with the general principles of pharmacology rather than overwhelm them with practical details. It includes excellent short discussions on biological assay and the testing of new drugs. The newer therapeutic agents are discussed thoroughly, if somewhat briefly, and the use of British terminology offers little inconvenience. The well-organized text and the abundance of illustrations should contribute to the book's usefulness for the medical student. It should prove useful to the physician as a survey of pharmacology and for the identification of the newer therapeutic agents.

The Thyroid: A Physiological, Pathological, Clinical and Surgical Study. By T. Leviti, M.A., F.R.C.S., F.R.C.S.I., Hunterian Professor of Royal College of Surgeons of England. Cloth. $20. Pp. 606, with 502 illustrations. Williams & Wilkins Company, Mount Royal and Guilford Aves., Baltimore 2; E. & S. Livingstone, Ltd., 16 and 17 Teviot Pl., Edinburgh 1, 1954.

In 25 years of study of the thyroid the author has critically examined specimens from over 2,000 thyroidectomies. He has studied these from a clinical, macroscopic, and microscopic viewpoint and has attempted to correlate these three methods of study. He offers as a basis for further research and discussion six phases of the toxic thyroid: (1) epithelial hyperplasia, (2) lymphoepithelial hyperplasia, (3) focal lymphoid hyperplasia, (4) diffuse lymphoid hyperplasia, (5) fibrolymphoid hyperplasia, and (6) fibrosis. He then correlates these stages with the clinical findings. This treatise contains chapters on all phases of thyroid disease and its complications as well as good descriptions of the anatomy and function of the gland. The hormone relationships are well covered. The photographs and plates are excellent; many are in color. The chapters on treatment are up-to-date and well presented. Although some original and controversial ideas are offered, this book should be valuable to students of the thyroid as well as to the practicing physician and surgeon.

QUERIES AND MINOR NOTES

RECURRENT CARDIAC ARREST

To the Editor:—*What is the likelihood of a recurrence of cardiac arrest during operation in a patient with a history of having had cardiac arrest in a previous operation? What is the advisability of elective surgery in a patient with such a history who has no evidence of heart disease now?*

Leo M. Smith, M.D., Stamford, Conn.

Answer.—When the heart stops beating one of two conditions is always present. The heart shows either ventricular fibrillation or ventricular standstill (asystole). Each condition produces irreversible damage in the brain unless steps are taken immediately to supply oxygen to the brain. This is the first and most important step to be taken for successful resuscitation. After this step has been taken and the oxygen system has been restored, then attention is directed to the restoration of the heart beat. A coordinated beat can always be restored to a normal heart but it cannot always be restored to a diseased heart. If it is restored, the heart may stop beating again or it may show standstill or fibrillation. For this reason the resuscitation team should be on guard after the heart has been resuscitated so that the chest can be reopened and another attempt made to restore the beat. The need for repetition of the procedures is not unusual. If the coordinated beat has been restored, if the patient has recovered consciousness, and if there is no brain damage, then the probability of repetition becomes increasingly remote with the passage of time. If the heart is the center of disease, such as coronary artery disease, and especially if the patient shows cerebral damage, then the probability of death in the next 24 or 72 hours is great. If the patient has a normal heart and if he shows no cerebral damage after the procedure is over, the probability of recurrence after several days is remote. There is no information to indicate that, if a patient with a normal heart has cardiac arrest and is successfully resuscitated, he will develop cardiac arrest next month or next year when another anesthetic is given, but, if the patient has an abnormal heart, the probability of recurrence may exist. This probability should be no greater than in another patient with a similar cardiac condition.

TONSILLECTOMY AND POLIOMYELITIS

To the Editor:—*1. Is there any objection to giving a patient the Salk polio vaccine one week after tonsillectomy? 2. Is tonsillectomy contraindicated within one to two weeks after the patient receives the Salk vaccine?*

Maxwell Spring, M.D., Bronx, N. Y.

Answer.—There is substantial evidence of an increased risk of poliomyelitis, especially bulbar, during the immediate postoperative period following tonsillectomy (Anderson, Anderson, Skaar, and Sandler: *Ann. Otol. Rhin. & Laryng.* **59**:602-613 [Sept.] 1950). This short-term risk has been documented only for patients operated on during epidemics of the disease. There is also evidence, however, of a relatively high incidence of bulbar poliomyelitis in persons subjected to tonsillectomy at longer intervals before onset of the disease (*J. A. M. A.*, **154**: 1180-1181 [April 3] 1954). No reason is evident why administration of the Salk vaccine following tonsillectomy should be expected to increase the risk of poliomyelitis. The vaccine is treated with formaldehyde to inactivate the poliomyelitis virus, which is its essential constituent. The tests employed to assure completeness of inactivation appear adequate to exclude any residual infectivity of the vaccine. It is true that during epidemics of poliomyelitis, some correlation has been found between the site of paralysis and the site of recent injections of various nonviral agents (*J. A. M. A.* **149**:170 [May 10] 1952). Conceivably an inactivated poliomyelitis vaccine, administered to someone already infected, might be capable of such a nonspecific effect. There is no evidence so far, however, that this is the case.

DESENSITIZATION TO WASP STING

To the Editor:—*A 12-year-old boy was stung by a wasp and within 15 minutes a generalized urticaria developed with moderate edema of the glottis. How can he be desensitized? Might this sensitization recur after he has once been desensitized?* *John K. Humphries, M.D., Columbus, Ohio.*

Answer.—It is doubtful whether desensitization is necessary in this case unless exposure to wasp stings is of more than average frequency. Most people go through life without a wasp or bee sting. Since desensitization is rarely permanent, this patient would have to go through years of injections for protection against a wasp sting that he might never experience again. It would seem more logical in this case to train the patient and his family in the immediate care of a wasp sting. This means the ready availability of epinephrine (obtainable in an ampul-needle combination), which should be used at once and may be followed by an injectable histamine. Desensitization is advisable when the patient is in an occupational or other environment in which he is likely to get repeated stings. An extract of wasps is obtainable from commercial houses, or it may be prepared on order. Usually the body of the insect minus the poison sac is employed in preparing the antigen, since it has been proved that the susceptible person is allergic to any portion of the wasp and not specifically to the venom. The latter may interfere in its diagnostic and therapeutic use because of its chemically irritating qualities. The initial doses to be chosen for desensitization would depend largely on the potency of the preparation and the degree of sensitivity of the patient. As a rule this is ascertained after scratch tests with serial dilutions of the antigen, followed by intradermal tests in high dilution. The initial concentration used in treatment may be the one that gives the minimal reaction by intradermal tests. Desensitization proceeds by gradual increments, perhaps twice weekly, or oftener if desired. The patient should be able to tolerate the most concentrated preparation before he can be considered immune. As is true with all desensitization, tolerance begins to diminish when injections are discontinued. It would be advisable to test the patient at intervals to determine the status of his immunity.

ULTRAVIOLET LIGHTS FOR SCHOOLS

To the Editor:—*The Parent Teacher's Association of a small country school is considering placing ultraviolet lights in the school room to prevent so many common colds and other diseases that are air borne. How effective is this procedure?*

M.D., Montana.

Answer.—The use of ultraviolet lights for disinfecting purposes has been shown to have some value in preventing cross infection under rather limited conditions, such as in hospital nurseries. Their use in theaters, barracks, industrial plants, assembly halls, waiting rooms, schools, or similar gathering places has not proved particularly effective in lowering the incidence of air-borne infection. Whatever protection might be afforded to the occupants of the schoolroom is lost when they leave the room. Thus, since the migration of the students from protected to unprotected areas during their daily activities cannot be regulated, no material decrease in the incidence of the respiratory infection simply because ultraviolet lights are used to radiate the air in the schoolroom occupied during only part of the day is to be expected.

The answers here published have been prepared by competent authorities. They do not, however, represent the opinions of any official bodies unless specifically so stated in the reply. Anonymous communications and queries on postal cards cannot be answered. Every letter must contain the writer's name and address, but these will be omitted on request.

PROGRESSIVE BULBAR PALSY

To the Editor:—*A 65-year-old woman with bulbar palsy, whom I have known for 20 years, is married and has had five children. Other than a vaginal repair about 10 years ago after childbirth she was well until 2 years ago when she complained of difficulty in speech and some drooling. Her blood pressure was 140/80 mm. Hg, heart and lung examinations were negative, urinalysis was negative, and the blood picture was normal. There were no indications of a stroke. A consultant suggested massive doses of vitamin B_{12} twice a week and prostigmine three times a day. Six months ago she started to complain of inability to swallow heavy foods. She can swallow soft foods and liquid but cannot stick out her tongue, and she drools more now. Have you any suggestions as to treatment?*

John J. Kerwin, M.D., Chicago.

This inquiry was referred to two consultants, whose respective replies follow.—Ed.

Answer.—There is more than one type of bulbar palsy, but it is assumed this patient has progressive bulbar palsy, inasmuch as there has been increasing inability to speak and swallow. This diagnosis may be confirmed by the presence of profound atrophy with fasciculations of the tongue and the absence of sensory changes or pyramidal tract involvement. This disease results from a progressive degeneration of the motor nuclear centers in the medulla. There is no known treatment for it.

Answer.—Unfortunately progressive bulbar palsy is invariably fatal, and no treatment has been shown to have any effect on it.

FETAL MORTALITY

To the Editor:—*What is the fetal mortality in breech delivery in a nulliparous woman of the 27-year-old group? What is the maternal mortality of elective cesarean section as compared to delivery from below? The question arose from a discussion of a case at our hospital staff meeting, in which the physician, on the basis of a roentgenogram of the fetus, felt that delivery from below was too risky because of a "big breech." Others felt that delivery from below would have been the procedure of choice.*

Harley C. Carlson, M.D., Sidney, Mont.

Answer.—With experienced obstetricians the mortality in breech delivery of near-term or full-term babies is not much higher than the death rate in head presentations. With average physicians the mortality for babies in breech presentations is at least twice as high as in head presentations. In maternity hospitals and general hospitals with a staff of competent obstetricians, the maternal mortality in elective cesarean sections today is almost zero. However, with average operators, the death rate from elective cesarean section is considerably higher than the maternal mortality after vaginal delivery. In the large majority of cases, babies presenting by breech should be delivered through the vagina; however, in women over 35 years of age having their first baby, it is justifiable to perform an elective cesarean section. Likewise, if there is a borderline indication for cesarean section and the baby presents by the breech, one may decide on a cesarean section.

IMMUNITY

To the Editor:—*I would like to know if the administration of cortisone or corticotropin (ACTH) interferes with the development of immunity or hyposensitization, when the physician injects tetanus toxoid or pollen extracts into a patient.*

M.D., Pennsylvania.

Answer.—Clinical experience indicates that the concomitant use of corticotropin or cortisone does not interfere with the hyposensitizing process with specific pollen or other allergens. While the experience with tetanus toxoid and other immunizing injections under the influence of this hormone is not as great, the general opinion is that it does not interfere with immune processes.

THE SEX RATIO IN FAMILIES

To the Editor:—*In an article in* Science, *Nov. 6, 1953, on the effects of irradiation at Nagasaki it is said that conventional genetic theory suggests that irradiation of the mother should decrease the percentage of males born and irradiation of the father should reduce the percentage of females born. Does the fact that, in some families in which irradiation is not a factor, the children are all or nearly all of one sex indicate that there is anything the matter with the body of the father or mother?*

M.D., Tennessee.

Answer.—While there is some evidence that factors other than chance may play a part in determining the sex ratio in some families, chance alone can account for a wide variability in the sex ratio. When n equals the number of children in a family, $\frac{1}{2}^n$ equals the chances of all of the children in a given family being boys or of them being girls. This is based on the assumption that the chances of being a boy or of being a girl are about equal. Thus in families of 10 children the chances of them all being boys are $\frac{1}{2}^{10}$. In 1,024 families of 10 children each, one family would be expected to be all boys. In the light of this, it does not seem necessary to conclude that there is anything the matter with the body of the father or of the mother in cases in which the children are all or nearly all of one sex.

MORPHINE SULFATE IN SOLUTION

To the Editor:—*The morphine sulfate solution (16 mg. per cubic centimeter) that I bought several months ago is now turning brownish or tan, even though the vials have not been opened. Is this solution safe and effective for parenteral use? The vials are not dated.*

M.D., Michigan.

Answer.—This question has not yet been answered satisfactorily. According to the report of the British investigators (Foster, MacDonald, and Whittet: *J. Pharm. & Pharmacol.* **2**:673, 1950), a pharmacological test revealed no decrease in the analgesic activity of discolored samples of morphine injection. A representative of a large pharmaceutical manufacturer supplying injectable solutions of morphine who was asked to comment on this question writes as follows: "We could not recommend that discolored solutions are safe to use, although there is no evidence that use of such solutions is dangerous. The nature of the pigment formed has not been established. We stop selling lots of our morphine sulfate injectable solution as soon as the stability samples show significant discoloration. This is done primarily as a precaution and for our own protection, rather than because we believe the use of the discolored solutions is harmful."

POSTMORTEM BLOOD SUGAR

To the Editor:—*A patient with mild diabetes died recently after an acute illness. A blood sugar determination at postmortem examination, performed on the unembalmed body about 12 hours after death, was 60 mg. per 100 cc. Assuming that the body was kept at room temperature, how can the approximate value of the blood sugar at the time of death be determined?*

M.D., Arizona.

Answer.—It is not stated whether the blood was taken from the left or right side of the heart. This is of great importance if errors caused by the postmortem diffusion of dextrose to the right side of the heart from the liver because of hepatic glycolysis are to be avoided. Hill (*Arch. Path.* **32**:452, 1941) found that, in the normal animal, the sugar content of blood in the right auricle increased rapidly after death, reaching a level of 400 mg. per 100 cc. in two hours and of 720 mg. per 100 cc. at the end of four hours. In contrast, if blood was taken from the left ventricle, it fell from 93.5 to 28.7 mg. per 100 cc. in five hours. Fasting animals or patients with marked hepatic damage do not show this postmortem rise in dextrose. Hill also found the rate of glycolysis in blood removed from normal human subjects to be 12.8 mg. per 100 cc. per hour at 37.5 C (99.5 F); at 27.5 C (81.5 F) there was a fall of 5.68 mg. per 100 cc. per hour and at 3 C (37.4 F) of 1.08 mg. per 100 cc. per hour. He concluded that for significant results in patients in whom hypoglycemia is suspected, specimens of blood should be taken within

two hours after death. Shields Warren in "The Pathology of Diabetes Mellitus" (ed. 2, Philadelphia, Lea & Febiger, 1938) recorded (table 46) the decrease in blood sugar of defibrinated blood at room temperature for various hours in two cases. In one the fall was from 460 to 16 mg. per 100 cc. in 26 hours and in the other from 300 to 113 mg. per 100 cc. in 24 hours and 35 minutes. He compared (table 47) antemortem and postmortem blood sugar values in 38 cases with data showing the number of hours to death and the number of hours to autopsy. No formula is given for the rate of fall. Another complication to be considered in any given case would be the presence or absence of bacteremia. The evidence available does not warrant even an approximate value of the blood sugar at time of death in the case described in the query.

ACUTE JOINT PAINS

To the Editor:—*A 48-year-old man has had joint pains for six years. Almost all joints of the extremities have been involved at some time. One or more joints are involved during an attack. The joints become swollen, red, very painful, and tender to touch. Attacks last about 24 hours with no residuals. Almost every day he has a painful joint, and severe attacks occur about every three weeks. Examination in December, 1953, was negative except for a small nodule over the left olecranon and on the plantar aspect of the left big toe. Roentgenograms of the hands and feet were normal. The fasting blood uric acid value was 6.2 mg. per 100 cc. The patient was given colchicine for one month without benefit. He was then given 0.5 gm. of probenecid (Benemid) daily, and after about 10 days, during which attacks were more frequent, there was marked improvement with complete freedom from symptoms for about 10 days. Symptoms then recurred, and although probenecid was gradually increased to 2.5 gm. daily along with colchicine, there has been no improvement. His blood uric acid is now 3 mg. per 100 cc. I would appreciate your opinion as to diagnosis and further treatment.*

M.D., Canada.

Answer.—The diagnosis is probably gout. The story and the original blood uric acid are entirely consistent. The drop in blood uric acid with probenecid is not surprising, though it is greater than usually seen. The recurrence of symptoms with the use of probenecid is not unusual. The patient should be given another therapeutic test with 0.6 mg. of colchicine every one or two hours until diarrhea occurs. If the nodule still persists on his olecranon, biopsy of it and fixation of the specimen in absolute alcohol would aid in diagnosis, if urate crystals were found.

NEPHRITIS AND CLIMATE

To the Editor:—*A patient, 56 years of age, is suffering from chronic nephritis and has 0.12% urine albumin. The sediment shows a few red blood cells and 1 to 3 granular casts per high power field. His last blood pressure reading was 130/85 mm. Hg, but he has shown edema of the dependent parts for a few weeks. Blood urea nitrogen was 24 mg. per 100 cc. one month ago, nonprotein nitrogen 51 mg. per 100 cc., and urea clearance 67% of normal. I recommended a vacation in a dry climate.*

M.D., New York.

This inquiry was referred to two consultants, whose respective replies follow.—Ed.

Answer.—From the description, azotemia is slightly greater than would be expected from the level of urea clearance. Possibly the patient is accustomed to a high protein ration. There is nothing to prove that he would be demonstrably benefited by severe protein restriction. However, moderate restriction at a level of 0.75 or 1 gm. per kilogram body weight might be advised, more because of the demonstrated ill effects of high protein feeding in experimental serum nephritis in rats than because of cogent clinical evidence. The edema is presumably hypoproteinemic rather than cardiac. It would be lessened by sodium restriction at a level of about 1 gm. daily. There is no evidence that climate or vacations materially alter the course of chronic glomerulonephritis; vacations as such are desirable and are most enjoyed in attractive surroundings in which there is a low incidence of disease of the upper respiratory tract. The choice then is what he can afford and will enjoy and where he can have a reasonable chance of maintaining some control over dietary sodium intake.

Answer.—It is difficult to give an exact answer to this inquiry. It is true that patients with chronic glomerulonephritis and edema did remarkably well in the desert climate of North Africa, especially in the Libyan Desert and the Sahara. This was usually ascribed to the dry atmosphere. It was surmised that in this dry climate the blood vessels of the skin react differently than is the case in a humid climate. Since it was believed that vasomotor reactions in the kidney and in the skin ran parallel, it was reasoned that therefore vasomotor reactions in the kidney, which allegedly were favorable for the course of the glomerulonephritis, would result from a sojourn in the desert. All this was completely hypothetical and was only used to find an explanation for the empirical observation that patients with glomerulonephritis reacted favorably when they moved to the Sahara. Be this as it may, a desert climate alone is not sufficient.

ERYTHRITYL TETRANITRATE

To the Editor:—*A 69-year-old man with chronic coronary disease fractured a rib, and two days later occlusion of a branch of the central artery in one eye developed. Five days later he was given 30 mg. of erythrityl tetranitrate by mouth every 4 hours for 3 weeks, during which time the resulting scotoma decreased somewhat in size. The patient has an unusually severe polyuria. The urine, with exception of its volume, is normal. Could the drug cause this, and could it in the long run be damaging the heart? If not, for how long should the medication be continued or would some other treatment be preferable? Is it likely that the accident caused the occlusion?* *L. J. Schwarz, M.D., Wildwood, N. J.*

Answer.—It seems most unlikely that the rib fracture caused the occlusion of a branch of the central artery of the retina. Erythrityl tetranitrate usually increases diuresis in patients with marked hypertension but probably is not the only cause of the increased urinary volume in this patient. There is no reason to believe that the drug injures the heart. If the scotoma is disappearing and the patient is having no difficulties with his heart, the drug could be discontinued reasonably soon.

IMMUNIZATION OF NEWBORN INFANTS

To the Editor:—*A recent article dealt with the administration of triple vaccine (diphtheria, pertussis, and tetanus) to newborn infants on their first neonatal day. I have also heard of other physicians practicing this early immunization procedure. Has there been any research that proves that immunization of newborn infants on the first day of life followed by two more injections at monthly or six week intervals is effective?* *William K. Carlile, M.D., Fort Yates, N. D.*

Answer.—Dating particularly from Baumgarten's paper "Relationship of Age to Immunological Reactions" in 1934, a number of articles concerning immunization in the newborn have appeared in the literature. However, the term "newborn" in the titles of such papers usually does not mean that immunization is to be undertaken on the first day of life. Nevertheless, Hesselvik and Vahlquist of Sweden reported (*Acta paediat.* [supp. 83] **40**:109, 1951) that they practice BCG vaccination at birth, but do not begin the triple antigens until infants are 3 months of age. Di Sant' Agnese revived interest in this subject a few years ago with several publications, one of which was titled, "Simultaneous Immunization of Newborn Infants Against Diphtheria, Tetanus and Pertussis: Production of Antibodies and Duration of Antibody Levels in an Eastern Metropolitan Area" (*Am. J. Pub. Health* **40**:674, 1950). More recently Dancis and Kunz (*Pediatrics* **13**:339, 1954) have reported "Studies of the Immunology of the Newborn Infant," part 6. There are probably extremely few pediatricians who would recommend instituting active immunization on the first day of life.

THYROID EXTRACT FOR MYOPIA

To the Editor:—*In the absence of clinical or laboratory evidence of hypothyroidism is there any indication for administering thyroid extract to children because of myopia?*

John B. Welsh, M.D., La Jolla, Calif.

Answer.—Duke-Elder points out (Textbook of Ophthalmology, vol. 4, London, Henry Kimpton, 1949, p. 4287) that "there is no more evidence that the dioptric constituents of the healthy eye can be altered or its rate of growth in a healthy child regulated, no matter what its refraction condition may be, than that the growth of any other part of the body can be controlled. Nor is there evidence that the simple myopic eye is unsound . . . deficient, or a victim of disharmonies of artificial civilization. . . . In simple cases as far as concerns the management of the patient, whether adult or child, the extent to which spectacles are worn, the amount of near work done, peculiarities of diet, or the administration of drugs are immaterial, provided that hygienic conditions are good, overstrain is avoided and general standards of health and development are maintained."

ALKALOSIS

To the Editor:—*What is the mechanism of hypochloremic alkalosis or hypokalemic alkalosis or both? Why does potassium correct this state?*

Emmet F. Ferguson, M.D., Birmingham, Ala.

Answer.—Losses of potassium from the body either in urine or via extrarenal routes produce fairly characteristic alterations in serum solutes, provided dehydration and renal failure are not present. These consist of a decrease in serum potassium and chloride, with a rise in the bicarbonate content. The facts available to date suggest that this change represents a metabolic alkalosis resulting from a loss of chloride from the extracellular space either via urine or into nonextracellular sites, and an entry of hydrogen and some sodium into body cells, including those of the kidney, presumably as a replacement for potassium. The net effect is an intracellular acidosis and an extracellular alkalosis. The administration and retention of potassium replaces cell deficits of this ion evicting the excess hydrogen and sodium and restoring cell and extracellular concentrations of electrolytes and hydrogen ion to normal. The intermediate events in this sequence have not been fully defined.

POSTPARTUM AMENORRHEA

To the Editor:—*A 33-year-old woman was delivered of a full-term girl on July 19, 1953. The delivery was normal in every respect. One week after the delivery she had a severe uterine hemorrhage. She had a transfusion and curettage for retained secundae. Afterward she was amenorrheal. Her general condition was good. She was treated with thyroid extract, estrogens orally and intramuscularly and progesterone, but the menstruation did not return. What further treatment should be tried?*

M.D., New York.

Answer.—There are a number of causes for amenorrhea in a woman 33 years of age. It is assumed that the patient is not pregnant now or does not have a missed abortion. The fact that delivery and a severe uterine hemorrhage one week later have been followed by amenorrhea for 10 months raises the question of the possibility of a necrosis of the anterior lobe of the pituitary (Sheehan's syndrome). This syndrome is associated with loss of much or all of the pubic and axillary hair and some of the other secondary feminine characteristics. The patient tends to gain weight and shows the findings associated with pituitary damage. In the less typical case these findings may not be pronounced. Such a syndrome might be determined by thorough and laboriously complicated endocrinological studies. These, as a rule, are not generally available and may be impractical in some instances. In order to make sure that the patient has not had an atresia of the cervix it would be advisable to perform a dilatation and curettage. An occlusion of the cervical canal would account for a hematometria. The tissue obtained by curettement might give some idea of the makeup of the patient's endocrinous situation. Later, an iodized oil (Lipiodol) instillation may be made as another test. A basal metabolic rate determination may indicate thyroid disturbances sufficient to account for this symptom. Glucose tolerance tests have at times yielded additional information. It is assumed that the red and white blood cell findings are normal. A roentgenogram of the chest should be obtained. A number of diseases may be associated with menstrual disturbances. Rarely will one be able to reinstitute ovulation if the patient is undergoing premature menopause or if there is a major disturbance in the pituitary or some other key gland in the endocrine system. Treatment should be directed at those conditions that may be positive causes. Since thyroid extract, estrogens, and progesterone have failed, their use should be discontinued until more information is available. Estrogens and progesterone might provoke some uterine bleeding, but this is not true menstruation.

MIGRAINE

To the Editor:—*A review of the literature indicates that migraine is probably due to initial and persistent vasoconstriction; the mechanism responsible for the migraine could be produced by a hyperfunction of the medullary and cortical zones of the adrenal glands, since there is evidence of the high concentration of the 17-ketosteroids in the urine of the patients during the period of the migraine attack; and ergonovine (Ergotrate) maleate is effective because it is an antagonist of the adrenergic substance. Taking into account the above data I have obtained a favorable response with intramuscular injections of 1 cc. of 1:2,000 solution of neostigmine (Prostigmin) bromide in the prodromal stage. Are my assumptions and treatment generally approved?*

Jorge Ruiz Martin, M.D., Chattanooga, Tenn.

Answer.—Well-substantiated observations from various sources have demonstrated that in migraine the head pain is experienced during the stage of vasodilatation. It is this arterial dilation with increased amplitude of pulsation that stimulates the pain-sensitive nerves in and around blood vessels that is presumed to cause the headache. Prior to the onset of the headache an initial vasoconstriction of the cerebral arteries produces visual and other preheadache phenomena but is seldom accompanied by pain. There is no conclusive evidence that the adrenal glands are responsible for migraine. High concentration of 17-ketosteroids in the urine, disturbances in electrolyte balance, variable changes in blood pressure, and other bodily disturbances have been reported in patients with migraine during the period of an attack. It is doubtful if any of these factors are responsible for development of a headache; they rather represent the effect of a participation of the neuroendocrine systems in an attack of migraine. The migraine syndrome is manifested by a widespread bodily dysfunction of painful and nonpainful character, the headache being but one aspect of a diffuse disturbance in function. Ergotamine preparations are effective in the treatment of migraine because of the direct action of the substance on the smooth muscles of the blood vessels, producing a constriction of these vessels with a decrease in amplitude of pulsation. This is particularly noticeable in the circulation of the external carotid. The ergot alkaloids also act centrally, and this action may contribute something to their efficacy. There is no evidence that ergotamine in the dose used in the treatment of migraine produces any adrenergic blocking effect. The use of parasympathomimetic drugs, such as neostigmine, has not been uniformly successful in the treatment of migraine.

LUPUS ERYTHEMATOSIS

To the Editor:—*Is sunlight detrimental only to the cutaneous lesions, only to the systemic lesions or to both in patients with disseminated lupus erythematosis?*

Jerome Robert Weinroth, M.D., New York.

Answer.—In patients adversely affected by sunlight, not only are the cutaneous lesions aggravated but all symptoms are made worse. The patient may indeed become very sick with fever and joint paints or with symptoms referable to any system.

JOURNALS ABSTRACTED IN THE CURRENT MEDICAL LITERATURE DEPARTMENT, MAY-AUGUST 1954

Abstracts have been made of important articles in the following journals in the Current Medical Literature Department of THE JOURNAL during the past four months. Any of the journals, except those starred, will be lent by THE JOURNAL to individual subscribers in Continental United States and Canada and to members of the American Medical Association and its student organization. No charge is made to members, but the fee for other borrowers is 15 cents in stamps for each periodical. Three journals may be borrowed at a time for a period not exceeding five days. Requests should be addressed to the Library of the American Medical Association. Thus most of these journals are accessible to the general practitioner.

*A. M. A. American Journal of Diseases of Children. Chicago.
*A. M. A. Archives of Dermatology and Syphilology. Chicago.
*A. M. A. Archives of Internal Medicine. Chicago.
*A. M. A. Archives of Neurology and Psychiatry. Chicago.
*A. M. A. Archives of Ophthalmology. Chicago.
*A. M. A. Archives of Otolaryngology. Chicago.
*A. M. A. Archives of Pathology. Chicago.
*A. M. A. Archives of Surgery. Chicago.
Acta chirurgica belgica. Brussels.
Acta clinica belgica. Brussels.
Acta endocrinologica. Copenhagen.
Acta gastro-enterologica belgica. Brussels.
Acta medica scandinavica. Stockholm.
Acta ophthalmologica. Copenhagen.
Acta paediatrica belgica. Brussels.
American Heart Journal. St. Louis.
American Journal of Clinical Pathology. Baltimore.
American Journal of Digestive Diseases. Fort Wayne, Ind.
American Journal of Gastroenterology. New York.
American Journal of Hygiene. Baltimore.
American Journal of the Medical Sciences. Philadelphia.
American Journal of Medicine. New York.
American Journal of Obstetrics and Gynecology. St. Louis.
American Journal of Pathology. Ann Arbor, Mich.
American Journal of Psychiatry. New York.
American Journal of Public Health. New York.
American Journal of Roentgenol. and Radium Therapy. Springfield, Ill.
American Journal of Surgery. New York.
American Journal of Syphilis, Gonor. and Venereal Diseases. St. Louis.
American Journal of Tropical Medicine and Hyg ene. Baltimore.
American Practitioner and Digest of Treatment. Philadelphia.
American Review of Tuberculosis. New York.
American Surgeon. Atlanta, Ga.
Anesthesiology. New York.
Angiology. Baltimore.
Annales de médecine. Paris.
Annals of Allergy. Minneapolis.
Annals of Internal Medicine. Lancaster, Pa.
Annals of Otology, Rhinology and Laryngology. St. Louis.
Annals of the Rheumatic Diseases. London.
Annals of Surgery. Philadelphia.
Antibiotics and Chemotherapy. Washington, D. C.
Archiv für klinische Chirurgie. Berlin.
Archiv für Psychiatrie und Nervenkrankheiten. Heidelberg.
Archives of Disease in Childhood. London.
Archives françaises de pédiatrie. Paris.
Archives des maladies du coeur et des vaisseaux. Paris.
Archives of the Middlesex Hospital. Edinburgh.
Archives of Pediatrics. New York.
Archives of Physical Medicine and Rehabilitation. Chicago.
Archivio per le scienze mediche. Turin.
Archivio "de Vecchi" per l'anatomia patologica e la medicina clinica. Florence.
Arizona Medicine. Phoenix.
Arquivos de cirurgia clinica e experimental. São Paulo.
Ärztliche Wochenschrift. Berlin.
Australasian Annals of Medicine. Sydney.
Australian and New Zealand Journal of Surgery. Melbourne.
Beiträge zur klinischen Chirurgie. Munich.
Beiträge zur Klinik der Tuberkulose. Heidelberg.
Belgisch tijdschrift voor geneeskunde. Leuven.
Blood. New York.
Brain. London.
British Heart Journal. London.
British Journal of Cancer. London.
British Journal of Dermatology. London.
British Journal of Industrial Medicine. London.
British Journal of Ophthalmology. London.
British Journal of Plastic Surgery. Edinburgh.
British Journal of Preventive and Social Medicine. London.
British Journal of Radiology. London.
British Journal of Surgery. Bristol.
British Journal of Urology. London.
British Journal of Venereal Diseases. London.
British Medical Journal. London.
Bulletin of the Johns Hopkins Hospital. Baltimore.
Bulletin of the Los Angeles Neurological Society. Los Angeles.
Bulletin of the New York Academy of Medicine. New York.
California Medicine. San Francisco.
Canadian Journal of Public Health. Toronto.
Canadian Medical Association Journal. Montreal.
Cancer. Philadelphia.
Chirurg. Berlin.
Circulation. New York.
Cirugía ginecología y urología. Madrid.
Clinica pediatrica. Bologna.
Clinical Science. London.
Connecticut State Medical Journal. New Haven, Conn.
Delaware State Medical Journal. Wilmington.
Deutsche medizinische Wochenschrift. Stuttgart.
Deutsche Zeitschrift für Verdauungs-und Stoffwechselkrankheiten. Leipzig.
Diabetes. New York.
Die Medizinische. Stuttgart.
Diseases of Chest. Chicago.
Diseases of the Nervous System. New York.
East African Medical Journal. Nairobi.
Edinburgh Medical Journal. Edinburgh.
Electroencephalography and Clinical Neurophysiology. Montreal.
Encéphale. Paris.
Endocrinology. Springfield, Ill.
Endokrinologie. Leipzig.
Eugenics Quarterly. New York.
Fortschritte auf dem Gebiete der Röntgenstrahlen vereinigt mit Röntgenpraxis. Stuttgart.
Gastroenterology. Baltimore.
Gazzetta medica italiana. Milan.
Geburtshilfe und Frauenheilkunde. Stuttgart.
Geriatrics. Minneapolis.
Giornale di clinica medica. Parma.
Giornale italiano di chirurgia. Naples.
Glasgow Medical Journal. Glasgow.
GP (Journal of American Academy of General Practice). Kansas City, Mo.
Harefuah. Jerusalem.
Der Hautarzt. Berlin.
Hawaii Medical Journal. Honolulu.
Helvetica medica acta. Basel.
Helvetica paediatrica acta. Basel.
Illinois Medical Journal. Chicago.
Indian Medical Gazette. Calcutta.
Industrial Medicine and Surgery. Chicago.
International Journal of Leprosy. New Orleans.
Journal of Allergy. St. Louis.
Journal of the American Geriatrics Society. Baltimore.
Journal of the American Medical Women's Association. New York.
Journal of Applied Physiology. Washington, D. C.
Journal of Bone and Joint Surgery. Boston and London.
Journal de chirurgie. Paris.
Journal of Clinical Endocrinology and Metabolism. Springfield, Ill.
Journal of Clinical Investigation. New York.
Journal of Clinical Pathology. London.
Journal of Experimental Medicine. New York.
Journal of the Faculty of Radiologists. Bristol.
Journal of the Florida Medical Association. Jacksonville.
Journal of Forensic Medicine. Cape Town.
Journal of Hygiene. London.
Journal of Immunology. Baltimore.
Journal of the Indiana State Medical Association. Indianapolis.
Journal of Infectious Diseases. Chicago.
Journal of International College of Surgeons. Chicago.
Journal of Investigative Dermatology. Baltimore.
Journal of the Iowa State Medical Society. Des Moines.
Journal of the Kansas Medical Society. Topeka.
Journal of the Kentucky State Medical Association. Bowling Green.
Journal of Laboratory and Clinical Medicine. St. Louis.
Journal of Laryngology and Otology. London.
Journal of the Maine Medical Association. Portland.
Journal de médecine de Bordeaux et du Sud-Ouest. Bordeaux.
Journal of the Medical Association of the State of Alabama. Montgomery.
Journal of the Medical Association of Georgia. Atlanta.
Journal of the Medical Society of New Jersey. Trenton.
Journal of Mental Science. London.
Journal of the Michigan State Medical Society. Lansing.
Journal of the National Medical Association. New York.
Journal of Nervous and Mental Disease. New York.
Journal of Neurology, Neurosurgery and Psychiatry. London.
Journal of Neurosurgery. Springfield, Ill.

* Cannot be lent.

Journal of Obstetrics and Gynaecology of the British Empire. Manchester.
Journal of the Oklahoma State Medical Association. Oklahoma City.
Journal of Pathology and Bacteriology. Edinburgh.
Journal of Pediatrics. St. Louis.
Journal of Pharmacology and Experimental Therapeutics. Baltimore.
Journal of the Royal Army Medical Corps. London.
Journal of the Royal Naval Medical Service. London.
Journal of the Tennessee State Medical Association. Nashville.
Journal of Thoracic Surgery. St. Louis.
Journal of Urology. Baltimore.
Journal-Lancet. Minneapolis.
Klinische Medizin. Vienna.
Klinische Monatsblätter für Augenheilkunde. Stuttgart.
Klinische Wochenschrift. Berlin.
Lancet. London.
Laryngoscope. St. Louis.
Lotta contro la tubercolosi. Rome.
Louisiana State Medical Society Journal. New Orleans.
Lyon chirurgical. Paris.
Maandschrift voor kindergeneeskunde. Leiden.
Manitoba Medical Review. Winnipeg.
Maryland State Medical Journal. Baltimore.
Medical Annals of the District of Columbia. Washington.
Medical Journal of Australia. Sydney.
Medicina. Mexico, D. F.
Medicine. Baltimore.
Metabolism. New York.
Military Surgeon. Washington, D. C.
Minerva chirurgica. Turin.
Minerva ginecologica. Turin.
Minerva medica. Turin.
Minerva otorinolaringologica. Turin.
Minerva pediatrica. Turin.
Minnesota Medicine. St. Paul.
Mississippi Doctor. Booneville.
Missouri Medicine. St. Louis.
Monatsschrift für Kinderheilkunde. Berlin.
Nebraska State Medical Journal. Lincoln.
Nederlandsch tijdschrift voor geneeskunde. Amsterdam.
Neurology. Minneapolis.
New England Journal of Medicine. Boston.
New York State Journal of Medicine. New York.
New Zealand Medical Journal. Wellington.
Nordisk medicin. Stockholm.
North Carolina Medical Journal. Winston-Salem.
Northwest Medicine. Seattle.
Obstetrics and Gynecology. New York.
Ohio State Medical Journal. Columbus.
Oncologia. Basel.
Pediatrics. Springfield, Ill.
Pennsylvania Medical Journal. Harrisburg.
Plastic & Reconstructive Surgery. Baltimore
Policlinico (Practical Section). Rome.
Practitioner. London.
Prensa médica argentina. Buenos Aires.
Presse médicale. Paris.
Proceedings of Royal Society of Medicine. London.
Proceedings of the Society for Experimental Biology and Medicine. Utica, N. Y.
Proceedings of Staff Meetings of Mayo Clinic. Rochester, Minn.
Proctology. Wisconsin.
Psychiatric Quarterly. Utica, N. Y.
Public Health Reports. Washington, D. C.
Quarterly Journal of Medicine. Oxford.
Quarterly Journal of Studies on Alcohol. New Haven, Conn.
Radiology. Syracuse, N. Y.
Revista de la Asociación médica argentina. Buenos Aires.
Revista brasileira de cirurgia. Rio de Janeiro.
Revista chilena de pediatria. Santiago.
Revista española de oto-neuro-oftalmología y neurocirugía. Valencia.
Revista de investigación clínica. Mexico, D. F.
Revista médica de Chile. Santiago.
Revista paulista de medicina. São Paulo.
Revue de la tuberculose. Paris.
Rheumatism. London.
Riforma medica. Naples.
Rivista di ostetricia e ginecologia. Florence.
Rocky Mountain Medical Journal. Denver.
Sang. Paris.
Schweizerische medizinische Wochenschrift. Basel.
Semaine des hôpitaux de Paris. Paris.
South African Journal of Medical Sciences. Johannesburg.
South African Medical Journal. Cape Town.
Southern Medical Journal. Birmingham, Ala.
Strahlentherapie. Munich.
Surgery. St. Louis.
Surgery, Gynecology and Obstetrics. Chicago.
Texas State Journal of Medicine. Fort Worth.
Thorax. London.
Thoraxchirurgie. Stuttgart.
Tidsskrift for den norske lægeforening. Oslo.
Tórax. Montevideo.
Transactions of the American Academy of Ophthalmology and Otolaryngology. Rochester.
Transactions of the Royal Society of Tropical Medicine and Hygiene. London.
Tubercle. London.
Ugeskrift for læger. Copenhagen.
United States Armed Forces Medical Journal. Washington, D. C.
Virginia Medical Monthly. Richmond.
Western Journal of Surgery, Obstetrics and Gynecology. Portland, Ore.
Wiener klinische Wochenschrift. Vienna.
Wiener medizinische Wochenschrift. Vienna.
Wisconsin Medical Journal. Madison.
Yale Journal of Biology and Medicine. New Haven.
Zeitschrift für Krebsforschung. Berlin.
Zeitschrift für Laryngologie, Rhinologie, Otologie und ihre Grenzgebiete. Stuttgart.
Zeitschrift für Orthopädie. Stuttgart.
Zeitschrift für Tuberkulose. Leipzig.
Zentralblatt für Gynäkologie. Leipzig.

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SUBJECT INDEX

This is an index to all the reading matter in THE JOURNAL. In the Current Medical Literature Department only the articles which have been abstracted are indexed.

The letters used to explain in which department the matter indexed appears are as follows: "E," Editorial; "C," Correspondence; "ab," abstracts; the asterisk (*) indicates an original article in THE JOURNAL.

This is a subject index and one should, therefore, look for the subject word, with the following exceptions: "Book Notices," "Deaths," "Medicolegal Abstracts" and "Societies" are indexed under these titles at the end of the letters "B," "D," "M," and "S." Matter pertaining to the Association is indexed under "American Medical Association." The name of the author, in brackets, follows the subject entry.

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Am.—American *Inst.—Institute*
A.—Association *Internat.—International*
Coll.—College *M.—Medical*
Comms.—Commission *Med.—Medicine*
Comm.—Committee *Nat.—National*
Conf.—Conference *Pharm.—Pharmaceutical*
Cong.—Congress *Phys.—Physicians*
Dist.—District *Soc.—Society*
Div.—Division *Surg.—Surgery*
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V 19

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1. Winkelstein, A.: Banthine for Peptic Ulcer: Clinical and Physiologic Considerations: A Preliminary Report, Gastroenterology *20*:464 (March) 1952.

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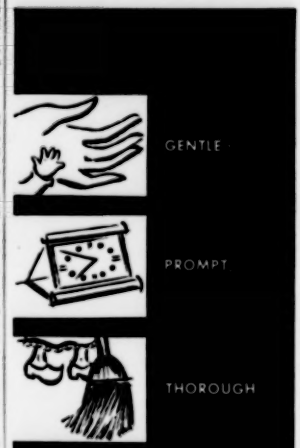

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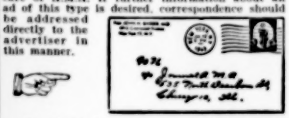

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Journal A.M.A., 535 N. Dearborn St., Chicago 10

NOTICE

Because of the Labor Day Holiday, classified advertising forms for the September 11 issue will close 13 days prior to day of issue instead of the usual 12 days.

NOTICE

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BOARD ELIGIBLE OPHTHALMOLOGIST—AS ASSOciate (not assistant) in extremely large New England ophthalmic surgery practice; do own surgery; refract only own patients; unexcelled hospital and clinic facilities; teaching opportunities if desired; start $15,000 to $15,000 depending on experience; increase every 6 months; percentage arrangement of partnership later; guaranteed $20,000 net after 4th year; send education, qualification, age, height 1st letter; opening available October 1st, but will wait several months if necessary; all applications strictly confidential. Box 7232 C/O AMA.

WANTED — GENERAL PRACTITIONER FOR MISsouri town; 1300 population; farming community; present physician called to service. Box 7256 C/O AMA.

(Continued on page 56)

Note the Nutritional Difference

THE superior nutritive value of enriched bread over unenriched bread is emphasized by analytical data recently published by the United States Department of Agriculture.[1] Comparison of the two kinds of bread indicates how much more effectively enriched bread contributes to nutritional needs.

Since enriched breads represent an estimated 85 per cent of all commercially produced bread, the evidence shows that bread enrichment has notably increased the B vitamin and iron intake of our population. For this reason enriched bread, since 1941 (when it was first marketed), has been a valuable aid in reducing the incidence of attributable deficiency diseases.[3,4]

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Because of its high nutrient value, its easy and almost complete digestibility, and its universally accepted pleasant, bland taste, enriched bread merits a prominent place not only in the general diet, but in special diets as well. In many reducing diets 3 or more slices daily are included. The average slice of machine-sliced enriched bread supplies only 63 calories.

At notably low cost, enriched bread is making a valuable contribution to the nutritional health of the American people.

1. Watt, B.K., and Merrill, A.L.: Composition of Foods—Raw, Processed, Prepared, United States Department of Agriculture, Agricultural Handbook No. 8, 1950.
2. Data furnished by the Laboratories of The American Institute of Baking, Chicago, Illinois.
3. Sebrell, W.H., Jr.: Trends and Needs in Nutrition, J.A.M.A. *152*:42 (May 2) 1953.
4. Flour and Bread Enrichment, 1949-50, The Committee on Cereals, Food and Nutrition Board, National Research Council, 1950.

The Seal of Acceptance denotes that the nutritional statements made in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.

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	Amounts	Percentages of Recommended Daily Allowances	Amounts	Percentages of Recommended Daily Allowances
THIAMINE	0.37 mg.	26%	0.08 mg.	6%
NIACIN	3.40 mg.	24%	1.40 mg.	10%
RIBOFLAVIN	0.23 mg.	14%	0.09 mg.	6%
IRON	4.1 mg.*	34%	1.09 mg.	9%

*An estimated amount of bread consumed daily by the average person.
**Daily dietary allowances recommended by the National Research Council for a 154 lb. man.

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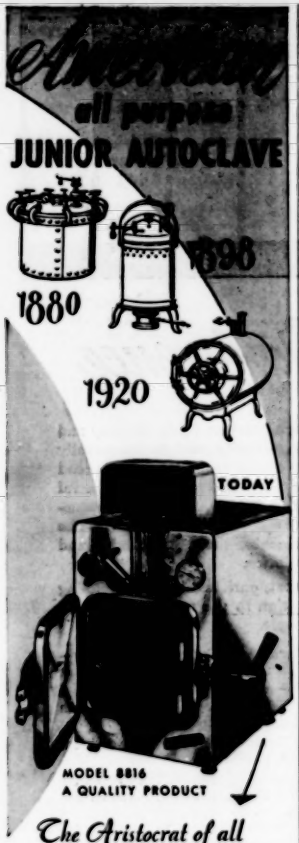

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TONICS AND SEDATIVES

my favorite story

In this space will be published anecdotes submitted by physicians concerning their practice or people in general. Contributions for "My Favorite Story" are welcome.

The soldier had returned after a long period overseas just one day before his wedding. He had scarcely seen his bride before the ceremony. Therefore, when the time for the kiss arrived, it was a long and lingering one. A sympathetic hush prevailed throughout the church until it was broken by a clear, childish voice asking, "Mommy, is he spreading the pollen on the bride now?"

The dapper young gentleman visiting an exclusive country club proceeded to the tennis courts to watch a championship match that was already in progress. Although the stands were crowded, he found a seat on a bench between two girls. Just as he sat down, a ripple of applause signified that a game had been won.

"Who's game?" he inquired generally.

The girl on his left looked at him carefully, and murmured, "I am."

the poetry corner

If all the trees in all the woods were men,
And each and every blade of grass a pen;
If every leaf on every shrub and tree
Turned to a sheet of foolscap; every sea
Were changed to ink, and all earth's living tribes
Had nothing else to do but act as scribes,
And for ten thousand ages, day and night,
The human race should write, and write, and write,
Till all the pens and paper were used up,
And the huge inkstand was an empty cup,
Still would the scribblers clustered round its brink
Call for more pens, more paper, and more ink.

—Oliver Wendell Holmes

did you know that . . . ?

In the eighteenth century the most extraordinary event occurred. For seventeen years (1736-1753), Albrecht von Haller was professor of surgery at Gottingen. Haller's learning and versatility were phenomenal, and he will always be placed among the greatest of physicians, but he should never have been professor of sur-

(Continued on page 52)

A gentle laxative modifier of milk. One or two tablespoonfuls in day's formula — or in water for breast fed babies — produces marked change in stool. Send for samples.

BORCHERDT MALT EXTRACT CO.
217 N. Wolcott Ave. Chicago 12, Ill.

Borcherdt MALT SOUP Extract

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This all-in-one-volume financial record book gets you started on the right foot in practice management—helps you avoid tax troubles—saves you time and money. It's the most practical and easy-to-use record system yet devised for your profession.

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As a special "get acquainted" offer to **doctors just beginning practice**, the DAILY LOG for 1954 is offered at the reduced rate of only 30c per month for the remainder of the year. A fair trial in your office will show you why the DAILY LOG is so highly recommended—why the re-order rate is over 90%. Satisfaction guaranteed or your money back.

Send for your DAILY LOG today—or write for your FREE Record Supplies Catalog

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New *Travert* (invert sugar) solutions combine with a wide range of other clinically-proven standard solutions to offer physicians and hospitals a specific formula for every case in which parenteral solutions are indicated.

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The original "closed system." Provides a means for collecting blood, storing it for a maximum period under vacuum, and then administering it. The system also offers a means of preparing plasma or serum, which may be stored almost indefinitely, and then administered as needed.

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There is a *Plexitron* expendable set for every phase of this parenteral program—for solution administration, for blood collection, and for blood and plasma administration.

from one source

—the exact solution and the specific equipment for any parenteral requirement. Uniform containers, standard closures, easy-to-use sets, and standardized procedures make this program easy to learn and efficient in operation.

No other program is used by so many hospitals

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DISTRIBUTED AND AVAILABLE ONLY IN THE 37 STATES EAST OF THE ROCKIES (except in the city of El Paso, Texas) THROUGH

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GENERAL OFFICES • EVANSTON, ILLINOIS

TONICS AND SEDATIVES *(Continued)*

gery for the one simple reason that he never performed a surgical operation.

♠

epitaphs —

The legends inscribed on grave stones are surprisingly a never-failing source of humour, and strangely enough, the attempts at humour are not accidental, but deliberate. Here are some examples:

Sacred to the Memory of
Jared Bates
He Died August 6, 1800
His Widow, Age 24, Lives at 7 Elm Street,
Has Every Qualification for a Good Wife,
And Yearns to be Comforted.

♠

Time magazine reports the following:

"Dr. William Rothwell, 71, well-loved town character, who always paid the check at parties; of heart disease; in Pawtucket, Rhode Island. His tombstone: A boulder inscribed, "This is on me."

♠

Beneath This Stone, a Lump of Clay,
Lies Annabelle Young,
Who on the 21st of May
Began to Hold Her Tongue.

♠

Here Lies Ann Mann;
She Lived an Old Maid and
She Died an Old Mann.

♠

Beneath These Stones Repose the Bones of
Theodosius Grimm.
He Took His Beer From Year to Year
And Then the Bier Took Him.

♠

This famous inscription on the tomb of Sir John Strange compliments him at the expense of the whole legal profession, and here it is:

"Here lies an honest lawyer, and that is Strange."

♠

A little boy was playing with his rather wretched-looking mongrel. A gentleman came by, and inquired in an amused voice, "What kind of a dog is he?"

The little boy very seriously said, "He's a police dog."

"He certainly doesn't look it," said the man.

"Well, he's in the Secret Service," replied the little boy.

♠

The young minister was talking to an aged member of his flock on the beauties of brotherly love, and the old man proudly announced, "Well, Reverend, I'll be 95 next month, and I can truthfully say that I haven't an enemy in the world."

"That's a great credit to you, sir," approved the minister, "How did you manage it?"

(Continued on page 54)

Valuable papers, confidential records, narcotics or dangerous drugs . . . they're all at *your* finger-tips, but perfectly concealed and safe from outside eyes and fingers. Yes, it's the exclusive Invincible Concealed Safe unit that provides convenient security PLUS the utility of an attractive, durable Invincible Filing Cabinet.

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Vol. 155, No. 4, Page 363 JAMA, May 22, 1954

Wet Alarm, for training enuretics, is an automatic device—simple, sensitive, safe. Awakent bedwetter immediately upon onset of urination . . . sets up a conditioned response of awakening and urethral sphincter contraction upon the stimulus of the distended bladder. Operated by a low-voltage battery. Does not plug into any electrical outlet. Harmless as a flashlight. Proved successful with enuretics from 3½ years up through adulthood. Contraindicated for the normal training of babies.

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Each small 2 Gm. suppository contains phenylmercuric acetate 0.02%, methylbenzethonium chloride 0.2%, and methylparaben 0.1% in a water-miscible base.

Box of 12 suppositories.

Also available: Lorophyn Jelly N.N.R.

EATON LABORATORIES
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TONICS AND SEDATIVES *(Continued)*

"Simple enough," was the reply, "I just out-lived them all."

♣

The waiter in a rather expensive restaurant hovered over his customer.

"And how did you find your steak, sir?" he inquired.

"It was sheer luck," sighed the hungry man, glumly, "I just happened to move a little piece of potato, and there it was."

♣

A new dish was being tried out on the two little children of the house. The girl pushed her plate away, saying, "I don't like it."

"Oh, you mustn't say that," cautioned her brother, "cause the more you don't like something, the gooder it is for you."

♣

A recent draftee was taken into service just before Christmas. However, he refused to take part in the festivities of the Christmas season at the barracks. When he was asked why, his reply was, "To hell with Santa Claus. Twenty years ago I asked him for a soldier suit, and now I get one."

♣

The sick man had been delirious with fever for days, but now he regained consciousness, and became aware of his comfortable bed, and the gentle assurance of cool, loving hands.

"Where am I," he asked weakly, "in Heaven?"

"No, dear," said his wife soothingly, "I'm still with you."

♣

The philosophy of Toots Shor, prominent New York restauranteur, can be summed up in his own words as follows, "I don't want to be a millionaire. I just want to live like one."

—D. D.

THE IMPROVED
MEDCOLATOR STIMULATOR 50B?

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Children, 25 mg., two to four times daily.
Some patients will require larger dosage. Because of the wide margin of safety of Neohetramine, dosage may be gradually and cautiously increased until a therapeutic effect is obtained or side effects appear. In the great majority of cases, the therapeutic dosage will not cause uncomfortable side effects.
Supplied: In tablets of 25 mg., 50 mg., 100 mg., in bottles of 100, and 1,000. Syrup, 25 mg. per teaspoonful (4 cc.) in pints and gallons. Cream, 2%, in one ounce tubes.

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(Continued from page 48)

OPHTHALMOLOGIST-OTOLARYNGOLOGIST — AM considering acquiring controlling interest established EENT practice; Mid-West; ideal community; good hospital connections; sufficient volume major surgery both specialties support 2 men; will need associate certified or qualified; my qualifications 7 years training both specialties, certified both Boards; age 38. Box 7249 C, % AMA.

VIRGINIA—CLINICAL DIRECTOR; MUST BE ELIGible for certification in psychiatry by Board of Neurology and Psychiatry; 5 years' experience in clinical psychiatry; 2700 bed state mental hospital; furnished house available on grounds; starting salary $11,472 per year. Apply to: Superintendent, Western State Hospital, Staunton, Virginia. C

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15 Peachtree Place, N. W.
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Write us for information about openings.
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WANTED — GENERAL PRACTITIONER; OPPORtunity; step into well-established general practice; hospitals nearby available; excellent rich agricultural community; county seat with population of 1,000; territory thickly populated; modern medical building. Fessenden Medical Center, Fessenden, North Dakota. Fred J. Mohr, Secretary. C

PHYSICIAN WANTED — SOUTHERN CALIFORNIA, near Los Angeles; well-established general practitioner, surgeon retiring because of health; brace new building, self equipment; easy terms; excellent opportunity; fast growing community. Mrs. W. G. Wheatley, 1027 San Gabriel Ave., Azusa, California. C

WANTED — YOUNG ASSOCIATE; RECENTLY trained in traumatic orthopedics, surgery and willing to assist in general practice; salary with partnership if mutually satisfactory; community in Georgia with modern clinical and hospital facilities; state qualifications. Box 7244 C, % AMA.

WANTED—PERMANENT RESIDENT PHYSICIAN IN an approved hospital; starting salary $6,500 per annum. Write: Administrator, Essex County Hospital, Belleville 9, New Jersey. C

GENERAL PRACTITIONER—SURGICAL EXPERIENCE preferred, not mandatory; to join young general practitioner, with established practice; new building; new large residential area adjacent to Los Angeles, California; no investment; start September or October. Box 7235 C, % AMA

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Write giving full particulars regarding personal history and work experience. Please include telephone number.

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EYE, EAR, NOSE, THROAT — PRIVATE PRACTItioner must have complete rest 3 months; wanted immediately; certified or eligible; to take charge extensive practice; financial arrangement open; not less than $18,000; permanent if mutually satisfactory. Mrs. John J. Ayash, 1005 4th Street Southeast, Minot, North Dakota. C

The Medical Bureau

PALMOLIVE BUILDING CHICAGO

ANESTHESIOLOGY: (A74) Head dept, conduct res training program, 350 bed hosp, affil. med. school, upper teaching
ASSISTANTS: (D85) By Board surg., chief department, 28 man group; univ. town, MW; surg. training not req. (D86) By GP; small town, So. Calif; $800 increasing to $1000 after 6 months.
EENT: (C21) Oph. thoroughly trained & well qual. eye surg. to head dept. important group; outstanding spot; staff of distinguished specialists; E. (C22) Oto or oph. to assoc with Board oto; well-estab'd city, 85,000, 2 colleges, Mid-South; full partner. (C23) Oph. head newly created dept well-estab'd group; coll. town, or lge city, univ. med. center; Pac. NW
GENERAL PRACTICE: (D88) Two GP's, one qual. surg. to take over county med. program for care of welfare clients; coll. town, 40,000; W. (D89) Ass't, group staffed by men long-estab'd; fine hosp. & lab'y connections; early partner, Calif. (D91) Ass't, 2 GP's; new clinic bldg; fine hosp. facilities; coll. town, 35,000; drawing pop. 60,000; Minn. (D92) To join staff, new 250 bed gen'l hosp. & clinics, foreign operations, major indust. co.; prof. one with 2 yrs' hosp. training including internship, two yrs' exp; $10,000, tax free, travel expenses
INDUSTRIAL MEDICINE: (E95) Med. dir; plant employing 7000; prof. one int. career in industrial med; training in ortho. or traumatic surg, req; $12-$14,000. (E96) Ass't med. dir; subsidiary, lge co; res. town, near lge city, med. center, E; $10,000
INTERNAL MEDICINE: (F 46) Head dept, small group Board men; res. town, resort area, Pac. NW. (F47) Gastroenterologist; 15 man group; univ. city, MW. (F48) Dipl. 35-45, priv. practice, join staff, 26 man group; coll. town, 45,000, Rocky Mt. state. (F49) Assoc. staff of med. lge teaching hosp; should be able leader, qual. to participate in training young men
OBSTETRICS-GYNECOLOGY: (G15) Head dept, 12 man group; coll. town on Gulf Coast; mild sub-tropical climate, no excessive humidity; early partner. (G16) Group ass't; rural area noted for duck hunting, Pac. NW; partner 3d yr
ORTHOPEDICS: (H75) Head dept, 12 man group; lge city, medical center, MW; early partner. (H76) Ass't, orthopedic group; E.
PATHOLOGY: (J73) Clin. path to supervise clinical path, one of country's leading priv. practice group, staffed by men on faculty med. school; excel. hosp. facilities. (J74) Assoc. path; busy priv. & hosp. pract, netting $30,000; excel. oppor. for expansion; lge city, med. center, MW
PEDIATRICS: (K11) Head dept, 12 man group; Diplo or eligible; new clinic bldg; excel. hosp. facilities; lake resort area, MW. (K12) Ass't with ped. & 2 OB-GYN men, Diplomates, eqpct partner; Calif. (K13) Ass't in 20 man group, Diplomates or elig; univ. city, W
PSYCHIATRY & NEUROLOGY: (L 46) Med. dir., child guidance center; half time only; $10,000; excel. oppor. prin. practice trade area, 250,000, Mid-South. (L47) Ass't, 2 Diplomates, P&N; busy priv. pract; lge city, med center, MW. (L48) Direct psy & med. services, dept of public institutions; wide latitude for independent operation; $12-$14,000.
PUBLIC HEALTH: (M91) Ass't dir., important health agency, Dipl. or elig; NYC; $12,000.
RADIOLOGY: (N35) Dir. dept, new vol. gen'l hosp., 300 beds; coll. town, W. (N36) Dir. dept, 16 man group estab'd '37; med. center, E.
SURGERY: (P16) Group ass't; coll. town, MW. (P17) Locum tenens, 9 months commencing Sept of Ort; group ass't; lge city, med. center, MW.

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Burnette Larson
DIRECTOR

(Continued on page 58)

"Mercaptomerin sodium [THIOMERIN sodium] *is an effective mercurial diuretic which produces much less local irritation on injection than other organomercurial compounds used for this purpose."*[1]

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1. Council on Pharmacy and Chemistry, American Medical Association: New and Nonofficial Remedies. J. B. Lippincott Co., Philadelphia, 1954, p. 349 • 2. Herrmann, G. R., and others: Texas State J. Med. *46*:75(Feb.) 1950 • 3. Grossman, J., and others: Circulation *1*:508 (April) 1950 • 4. Krehbiel, S., and Stewart, H. J.: J.A.M.A. *146*:250 (May 19) 1951

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(Continued from page 56)

PSYCHIATRIST WANTED—BOARD CERTIFIED OR eligible; to fill position with new state governmental alcoholic rehabilitation program in Florida, limited private practice possible. Box 7233 C, % AMA.

WANTED — PEDIATRICIAN, CERTIFIED OR ELIgible; for prepaid medical group; starting salary $9,100-$9,400 depending on qualifications; automatic annual increases; generous paid vacation, study, and sick leave; insurance and retirement system; excellent opportunity; give biographical details and state availability in reply. Medical Director, Group Health Association, 1925 Vermont Avenue, N.W., Washington 5, D. C. C

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GENERAL PRACTITIONER—WITH SOME SURGICAL experience; to associate with young general practitioner in small southern community; new fully-equipped 20 bed hospital; $1000 per month, full partnership after 1 year. Box 7252 C, % AMA.

WANTED — PEDIATRICIAN; 28 MAN GROUP IN upper mid-west college community; 225 bed hospital staffed with interns and residents; salaries open; moving expenses will be paid for interview. Box 7242 C, % AMA.

WANTED — RESIDENT PHYSICIAN; MARYVIEW Hospital, Portsmouth, Virginia; 140 bed general hospital; population 100,000; salary opened with or without maintenance. Apply: Mother Anne Gertrude, Administrator. C

WANTED — PEDIATRICIAN; AMBITIOUS; 28-36 years, old; to join well-established, 6 man group in Mid-South; salary $15,000 1st year, $18,000 2nd year, partnership thereafter. Box 7236 C, % AMA.

WANTED — INTERNIST; BOARD ELIGIBLE; FOR staff of new, modern, completely equipped, 75 bed general hospital in desirable location in the Carolinas; office space plus utilities furnished free of charge in hospital for at least 1 year; physician who has had part of an approved residency will be considered; not a salaried position; write complete credentials. Box 7164 C, % AMA.

PHYSICIAN—FOR A SMALL NORTHERN NEW YORK progressive industrial and farming city; excellent opportunity for a young general practitioner; give complete information. Box 7251 C, % AMA.

GENERAL PRACTITIONER—PROMISING LOCATION; western New York town about 5000; new hospital; possibility of alternate night calls with other physicians. Box 7238 C, % AMA.

WANTED—OBSTETRICIAN-GYNECOLOGIST; CERTIfied or qualified; for association with 35 year old, certified man; town of 40,000, South-East; county 90,000. Box 7249 C, % AMA.

OBSTETRICIAN—TO ASSOCIATE WITH OBSTETRIcian-gynecologist. Diplomate who is limiting practice to gynecology; excellent opportunity for physician to take over large obstetrical practice; eastern city. Box 7032 C, % AMA.

ASSISTANT RADIOLOGIST — BOARD MEMBER OR Board eligible; as associate in 400 bed approved hospital; affiliated with medical school; opportunity for man interested in teaching and research. Apply: Radiologist, Mount Sinai Hospital, Chicago 8, Illinois. C

WANTED—EENT OR OTOLARYNGOLOGIST; CERTIfied or eligible; with knowledge of office ophthalmology; by certified ophthalmologist; salary to start; excellent opportunity for young well-trained man; South-West. Box 7202 C, % AMA.

WANTED—OHIO; PHYSICIAN; IN LARGE STATE hospital+; good opportunity for experience in medicine, surgery, neurology and psychiatry; good salary with modern furnished home; must be a citizen of the United States; give full particulars when replying. Box 7190 C, % AMA.

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GENERAL: (a) asst. prin.; pract. Chgo. suburb; $8-$10,000 w/future principalship; erecting new 12 rm. office bldg.; must have auto & license. (b) asst. interest in surg.; Calif.; $600 up to depend. on qual.; future principalship.

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INTERNIST: $12-$15,000 & no expense except auto; grp of 24, well-est.; Ks. Dak.

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OB-GYN: (a) assoc. w/32 yr. old assoc. who has to restrict activities due to coronary; Eastern metropolitan area; well-equip. office & good hosp. connections; promise to $20M & on. (b) assoc. will retire 75%, of gross (b) location priv. pract.; central Fla.; beaut 56 bed hosp. can give ½ proposition; no opposit. w/in 40 miles; Dir. of hosp. is cert. (c) fully qual assoc. or associate w/2 yrs. of trng. who wants to go in for preceptorship work; sal. open; MW city of 100,000.

OPHTHALMOLOGY: perm. appointment w/good starting sal.; assn. of 18 full time phys. in pre-paid med. care program; easy South.

ORTHOPEDIST: $15M no. start; MW clin. of 13 AB members.

OTOLARYNGOLOGIST: captny. to be an asst in new mod. bldg. w/referrals from the other 3 BD's also practicing there; attractive future as only 1 EENT man in the area; north Calif.

PATHOLOGIST: (a) to supervise segment, and direction of dept. on full time status & take active leadership role in med. educ. program for intern trng & in med. staff scientific programming. Box Exp. 1; $12 mth.-$17,500. (b) Asst. Prof; South; to $9500 depend. on exper.

PEDIATRICIAN: assoc. w/2 cert. ped. who have to now refuse work b/c pract. is so busy; sal. 24 yrs; ½ w/priority; to 4.5 yrs; MW city of 52,000; essnl. hosp. facil.; new clin. bldg.

PRACTICE AVAILABLE: modern home-office for sale ideal in location & circumstance; phys. retiring. Address desk region; $5200 prty. subsidy; relatively little wkg work; cash income about $18,000; sale price of $30,000 includes office equipment & furnishings & many low furnishings; property free and clear.

PRECEPTORSHIPS: attractive opening yng. man starting in EENT field; good trng. w/living salary; Texas.

PSYCHIATRY: (a) Staff or Clin. Dir.; 1100 state hosp.; $W $7-$10,000 w/opp to do Supervisor Psych. & Ad. Service. & bed dept. in state mental hlth.; newly created position; $12-$14,000 & expenses; offers man challenge to use training & do outstanding job w/freedom of operation; Pac. MW.

PUBLIC HEALTH: (a) Pac. MW; basic to $11,520; grad. degree in PH & 3 yrs. of exper. req. (b) new organization wants phy with degree in PH; to become dir of county hlth dept; empl to be capable of organizing new dept. (c) Dir. of VD program; $6500 to start; California.

RADIOLOGIST: (a) assoc. position in 210 bed gen'l. supp hosp; 50 miles from Chgo. on Lake Mich.; $12,000 start w/advancement assured (b) assoc. w/Cert. man in chge. of Rad. dept's. in 2 Calif. hosp.; has priv. office for consultation & therapy & plans to retire in close future; financial arrange open.

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(Continued on page 60)

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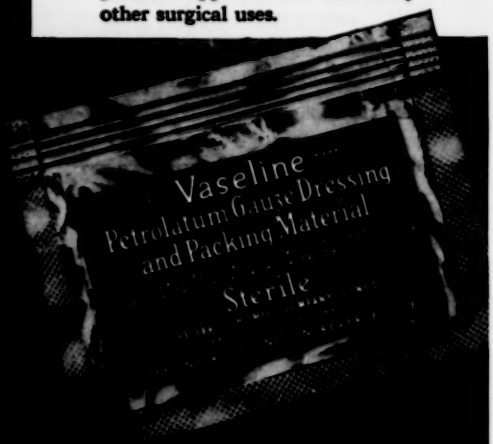

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(Continued from page 58)

PSYCHIATRIST WANTED—STATE HOSPITAL SOUTH, Blackfoot, Idaho; has opportunity for Board eligible or experienced psychiatrist; must be eligible for Idaho license; salary competitive; practice involves devoting at least half-time to interview therapy; opportunity for research; hospital has 800 patients; 8 psychiatrists; 5 clinical psychologists; unique organization for professional work; won 1954 Mental Hospitals Achievement Award. Contact: J. O. Cromwell, M.D., Superintendent, Box 598, Blackfoot, Idaho. C

LICENSED MD. ANESTHESIOLOGIST — FOR ANESthetic and clinic work; may have own private practice priv. Contact: Capitol Hospital, 1971 West Capitol Drive, Milwaukee, Wisconsin. C

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CLINICAL INVESTIGATION — LARGE MIDWEST ethical pharmaceutical company has opportunity for 4 physicians for clinical investigation work in the fields of (A) infectious disease (B) endocrinology (C) pharmacology (D) nutrition; prefer young man who has completed residency training and has Boards or is candidate for Boards in internal medicine; further training beyond residency desirable. Please outline qualifications and interests in letter to Box 7215 C, % AMA.

ASSISTANT PHYSICIAN WANTED—FOR OCTOBER 1, 1954; woman or man; for New England training school; full maintenance available at low charge; you can save most of the comfortable cash salary; come with us for a year before going into your residency; citizenship and State license required. Box 7216 C, % AMA.

WANTED—YOUNG, GENERAL PRACTITIONER, NEW York State licensed, in upper New York State; to work with a group; excellent hospital facilities; no investment required; guaranteed income. Address letters with full details to: Dr. George H. Gonyea, 202 Cornelia St., Plattsburg, New York. C

WANTED — PRECEPTEE FOR TWO YEAR RECOGnized preceptorship; mid-west plastic surgery clinic and 40 bed hospital; requirements: 1 year internship and 2 years general surgery residency. Box 7218 C, % AMA.

DRAFT-EXEMPT GENERAL PRACTITIONER wanted, as 50% partner; to live in modern home-office; surgical preceptorship in own 100 bed Detroit hospital; excellent remuneration. Box 7213 C, % AMA.

WANTED — YOUNG PHYSICIAN; TO HELP WITH general practice; teaching and industrial practice in western New York college community; new hospital; excellent schools; 18 miles from large medical center; starting salary $8000 to $12,000. Box 7227 C, % AMA.

CALIFORNIA — GENERAL PRACTITIONER OR INternist; to join two congenial doctors in fast growing Southern California community near coast; finest equipment; beautiful building; possibilities unlimited; $4,000 will handle. Box 7208 C, % AMA.

WANTED IMMEDIATELY — ASSOCIATE; FOR GENeral practice; in upstate New York; no investment; income about $12,000 1st year; excellent opportunity for well trained man, not over 45 years old; references required. Box 7211 C, % AMA.

WANTED — YOUNG PHYSICIAN FROM CLASS A medical school with adequate hospital training for an office doing industrial work and general practice; an excellent opportunity for an ambitious young man. Box 7200 C, % AMA.

WANTED IMMEDIATELY—FULL-TIME ASSISTANT radiologist; 3 hospitals; state training and exper.; exp in isotopes, availability, military status, and all information in 1st letter; state compensation expected. Box 7205 C, % AMA.

SURGEON-GENERAL PRACTITIONER — IMMEDIATE need of young general surgeon for association with MD, 36 years old; with active general and obstetrical practice in town of 7,000 in northwestern Minnesota; within an excellent hunting and fishing area; $1,000 per month until suitable arrangements can be made. Box 7201 C, % AMA.

WANTED — STAFF PHYSICIAN; IN PRIVATE neuropsychiatric hospital in South-West; psychiatric experience not essential but preferred; salary open; send as much information as possible 1st letter. Box 7229 C, % AMA.

WANTED — GENERAL PRACTITIONER; TO TAKE over practice in Boonton, New Jersey; 8,000 population; completely furnished office. Contact: Mrs. I. N. Griscom, 204 Church St., Boonton, New Jersey. C

ANESTHESIOLOGIST—BOARD ELIGIBLE; TO JOIN group in large mid-west city; private practice partnership with terms that will be attractive; immediate arrangements desired. Box 7207 C, % AMA.

Founders of the counseling service for the medical profession, serving medicine with distinction over half a century.

ADMINISTRATION: (i) Dir; gen hosp 600 beds; med sch affil; $15-$20,000. (ii) Ass't med dir; pref surgeon; 50 bed hosp; $20-$25,000; Calif.
ALLERGY: (c) Dipl to head dept; 53 man clinic-group
ANESTHESIOLOGY: (b) Dir dept; lease basis; lge gen hosp; should net $22-$25,000; recommended
ASSISTANTS: (a) By GP; By surgeon, Dipl &, also, internist; may do OB if interf'd; some to $5,000; S. (x) GP; duties medicine & some minor traumatic surg; indus; two 1 hr to 3 med schools; Ill.
DERMATOLOGY: (i) Ass't with 7 Board derm's, FACS; $12,500; college has 140,000; apply prtnr; MW.
EENT: (u) Oph. Hd dept; ear group; $18,000; early prtnr; W. (v) Oto; Ass't to 2 man group mostly Dipls; new clinic; town 50,000; MW.
GENERAL PRACTICE: (a) Immed p'tnr w long-estab'd MD w own 100 bed hosp; duties GP, surg, OB-Gyn; $18-$20,000 short time; lge city; univ med center. (b) GP; full thge med wrk'n & GPA; 100 bed hosp; Pac island; 2 yr contract; $9000. (c) Ass't with GP w inter in surg; duties int med & anes; to $12,000; S.
INDUSTRIAL MEDICINE: (a) Med dir; non-hotting center; 2000 empl; excel infirmary, 15 1st-aid stations; S. (x) 91st; two's tru's in ortho or traumatic surg; $12-$14,000 plus extras; semi-heavy steel fabricators; Ohio.
INTERNAL MEDICINE: (a) Trn'd in G-E; ass't; 13 man grp estab'd '98; pref man just out of res; prtnr 1 year, MW. (b) One inter'd cardiology or metabolic diseases; 14 man grp; own 205 bed hosp; teaching research; lge city; impor univ med center; Midd. (c) Ass't in gp long-est now expand'g; $12,000; shld get $18-$27,000 after estab'd; prtnr 3 years; Calif.
OBSTETRICS-GYNECOLOGY: (m) Hd dept; grp composed of surg, FACS, Board internist & GP; long-estab'd; replace man recalled; will not return; gyn surg well-developed; $12,000 1st yr then increas'g ¼ load'g to full prtnr; new clinic; two 90,000 ½ hr to 2 med schools.
ORTHOPEDICS: (h) With inter traumatic surg; ass't; 10 man grp; 14 Dipls; own hosp; lge city; univ med center, MW.
PATHOLOGY: (n) Assoc dir lab of cytology; one of most important units in country; apply faculty appt; prev tra'g not req'd. (o) Dir dept; gen hosp 250 beds; $15-$20,000; S.
PEDIATRICS: (t) Ass't; 20 man grp; lge city; univ med center; MW. (t) Hd dept; grp young specialists; apply $12-$15,000; early prtnr; Calif.
PUBLIC HEALTH: (d) Ass't dir county hlth program & faculty appt impor med sch; must be well-qual. P.H. & preventive medicine, MW.
RADIOLOGY: (r) Dir dept; gen hosp 260 beds; $15-$20,000; lge univ city; univ affiliation.
SURGERY: (a) Chief surg; grp 5 distinguished specialists; 3 Dipls; $12-$18,000; SW. (b) Ass't med dir 50 bed hosp; $20-$25,000; Calif.

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We offer you our best endeavors—our integrity—our 58 year record of effective placement achievement
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(Continued on page 62)

PEDIATRICS BULLETIN

Prepared In The Interests Of The Profession By The Pediatrics Consultant Staff Of H. J. Heinz Company

WHEN THE CHILD NEEDS MEDICINE, THE PARENT OFTEN NEEDS ADVICE

PARENTS of sick children sometimes criticize the doctor for not explaining in sufficient detail how to administer the medicine he so carefully prescribes.

• **It is well for us** to bear in mind that the average parent approaches a routine medical procedure with some apprehension. She is far more likely to meet difficulty when administering medicine than is the trained nurse. Children, quick to sense any unsureness or emotional distress, may refuse to take the medicine—or even cough it up.

• **Obviously,** there are no simple techniques the physician can advise for all situations. Much depends on the training of the child and on his relationship with the parent.

• **Yet if the doctor** will take time to recommend a specific procedure for administering his prescription, he will promote the self-confidence of the parent and, by so doing, facilitate the successful treatment of his young patient.

NOTE: The purpose of these bulletins is to help disseminate modern pediatrics knowledge to the general medical profession. They appear monthly in the Journal of the American Medical Association.

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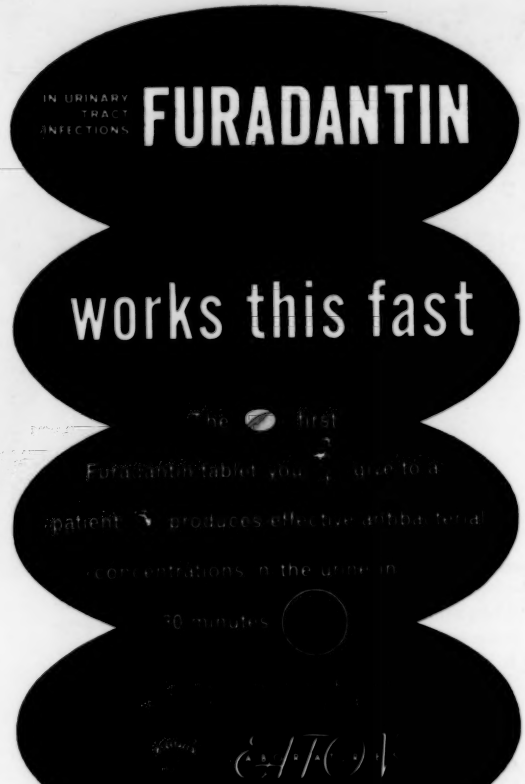

IN URINARY TRACT INFECTIONS
FURADANTIN
works this fast
The first
Furadantin tablet you give to a patient produces effective antibacterial concentrations in the urine in
30 minutes

(Continued from page 60)

ADVENTUROUS PHYSICIAN — FOR MAINE COAST Island; subsidy provided; funds available for constructing modern clinic; particularly attractive opportunity for man or woman desiring participation in community life and/or change from city practice. Maine Sea Coast Mission, Bar Harbor, Maine. C

GENERAL PRACTITIONER WANTED — TO TAKE over busy practice of former doctor now deceased; modern 21 bed hospital; excellent nursing staff; X-ray and laboratory technician; unlimited opportunity. Mrs. Thos. R. Skaggs, Memorial Hospital, Mt. View, Missouri. C

WANTED IMMEDIATELY — FULL TIME PSYCHI-atrist for out-patient clinic in State Receiving Hospital; preferably but not necessarily, Board member or Board eligible; stipend $10,800; privilege of housing on the grounds at nominal fee. Contact: Superintendent, Dr. J. M. Whitworth, Summit County Receiving Hospital, 330 Broadway, E., Cuyahoga Falls, Ohio. Box 208. C

PATHOLOGIST WANTED—WITH AT LEAST THREE years experience in general pathology; salary commensurate with experience. Write: G. B. Hennigar, MD, Box 817, Medical College of Virginia,* + Richmond, Virginia. C

SURGICAL PRECEPTEE WANTED — EXCELLENT salary; opportunity to do independent surgery if capable. Box 7068 C, % AMA.

WANTED—GENERAL PRACTITIONER WHO CAN DO surgery; modern, fully-equipped new hospital; county seat 1800 inhabitants; very large territory; 6 churches, good schools; 2 MD's, 2 dentists; no competition, but full cooperation; nothing to buy; collections 95% or better. Felix F. Vonnegut, MD., Linton, North Dakota. Phone 6611. C

PHYSICIAN—NEVADA COUNTY WITHOUT PHYSI-cian; large ranching area, mining town 700; good schools, churches; salary $500 month plus practice; office, residence furnished. Apply: Ed Delaney, Eureka, Nevada. C

INTERNIST — TO OCCUPY OFFICE IN MODERN medical arts building; owned and occupied by 8 physicians; extra income assured if doctor wishes to assist in operations or give anaesthesia. Dr. E. Greenberger, McAlester, Oklahoma. C

WANTED IMMEDIATELY—PHYSICIAN; TO BE IN charge of Alaska Department of Health marine health unit, M.S. hygiene, carrying generalized public health program to isolated coastal regions of territory; $5,460 or $7,260 to begin depending on qualifications; full subsistence provided. For further information write: C. Earl Albrecht, MD., Alaska Office Building, Juneau, Alaska. C

CALIFORNIA—CLINIC SPACE FOR FOUR OR FIVE doctors; laboratory, x-ray, modern equipment; available now; excellent opportunity for group or surgeon. Box 7178 C, % AMA.

WANTED IMMEDIATELY—ASSOCIATE; BY OLDER doctor wishing partial retirement; rural Kansas county seat; new modern hospital, opportunity for surgery; $45,000 practice; $12,000 1st year; qualified man equal partnership 2nd year. E. R. Beilderwell, MD., Leoti, Kansas. C

RADIOLOGIC ASSOCIATE WANTED—BY LONG ES-tablished Illinois radiologist; modern private office plus hospital appointments; state training, military and health status; licensure, when available, compensation 1st year. Box 6675 C, % AMA.

WANTED — PHYSICIANS AND PSYCHIATRISTS; full time; immediate openings; 120 bed State receiving hospital; southern Ohio; citizenship necessary; salary commensurate with experience. Box 7167 C, % AMA.

WANTED IMMEDIATELY—YOUNG PHYSICIAN; FOR general practice with industrial organization Nevada; good remuneration from salary and private practice. Write for details. Box 7174 C, % AMA.

WANTED — OPHTHALMOLOGIST; BOARD MEMBER preferred; under 45, to head department of ophthalmology. Contact: Dr. Arnold S. Jackson, Jackson Clinic, Madison, Wisconsin. C

WANTED—ASSISTANT PHYSICIANS; SALARY $5100-6600; large eastern State mental hospital +; approved 3 year residency program; training for Boards. Box 7194 C, % AMA.

ORTHOPEDIST—BOARD QUALIFIED FOR ESTAB-lished 16 man Arizona clinic with no orthopedic department; complete credentials desired. Box 7172 C, % AMA.

WANTED — DOCTOR WITH ONE YEAR GENERAL and 1 year obstetrical training; to work on salary for at least 2 years; license to practice in Tennessee; practice limited to obstetrics and gynecology in 50 bed hospital; annual salary $15,000. Box 7157 C, % AMA.

INTERNIST — BOARD CERTIFIED OR ELIGIBLE; group 13 specialists; junior partnership in 2 years. Apply: Dr. John Hershey, Department Internal Medicine, Holzer Clinic, Gallipolis, Ohio. C

WANTED — PHYSICIAN TO REPLACE RETIRING general practitioner in community of 3000 population in western Pennsylvania; good schools, hospital and living quarters; office equipment with drugs very reasonable. Box 7146 C, % AMA.

CHICAGO CIVIL SERVICE COMMISSION AN-nounces examinations for position of Assistant Commissioner of Health, Chicago Board of Health, $14,000 per year; new date October 18, 1954. For information call or write: Civil Service Commission, 208 City Hall, Chicago. C

WANTED—PEDIATRICIAN; BOARD CERTIFIED OR Board qualified; to associate with a board certified pediatrician already on our staff; 14 man clinic located near Chicago, Illinois; clinic services 100,000 population; salary open. Box 7140 C, % AMA.

OBSTETRICIAN-GYNECOLOGIST—PRECEPTORSHIP; with Diplomate; 2 year approved training required; large practice; some referred patients immediately; assist with regular practice; $7500 and advance; Midwest. Box 7155 C, % AMA.

GENERAL PRACTITIONER—CALIFORNIA; DO SUR-gery and OB; join 5 man general practice group with own hospital; 100 miles from San Francisco; start $12,000, opportunity full partnership. Pacific Coast Medical Bureau Agy., 703 Market, San Francisco. C

WANTED — GENERAL PRACTITIONER; IMMEDI-ately; no investment; excellent opportunity; town 6,000 large drawing area; should easily net $12,000 to $15,000 1st year. Chouest's Drug Store, Golden Meadow, Louisiana. C

HEMATOLOGIST—CALIFORNIA LICENSED; WANTED for well paying appointment. Continental Medical Bureau, Agency, Room 323, 510 West Sixth, Los Angeles 14. C

WANTED — PEDIATRICIAN; FOR SEVEN MAN group in mid-western city; above average facilities with excellent financial opportunity. Box 6883 C, % AMA.

SEVERAL IMMEDIATE APPOINTMENTS AVAIL-able; in various parts of California as county physicians, also assistant county physicians; $6,500-$10,000 plus furnished house. Business and Medical Registry, 610 South Broadway, Los Angeles, California. C

WANTED — DERMATOLOGIST FOR SEVEN MAN group in mid-western city; above average facilities with excellent financial opportunity. Box 6884 C, % AMA.

GENERAL WITH ANESTHESIOLOGY—CALIFORNIA licensed; 3 excellent openings. Continental Medical Bureau, Agency, Room 323, 510 West Sixth, Los Angeles 14. C

WANTED — YOUNG PHYSICIANS; INDUSTRIAL pharmaceutical and chemical companies and hospitals; psychiatrists, anesthesiologists. Brown's Medical Bureau, 7 East 42nd St., New York, New York. C

ANESTHESIOLOGIST — CALIFORNIA; JOIN DIPLO-mate and Chief Department fairly large hospital; attractive university town; salary basis 1st year. Pacific Coast Medical Bureau Agy., 703 Market, San Francisco 3. C

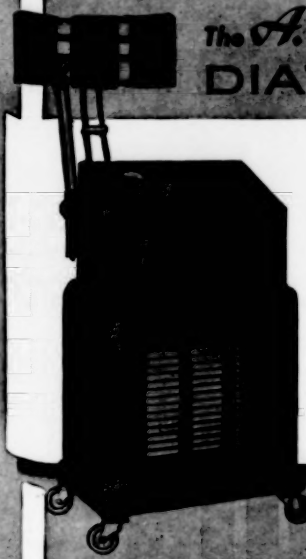
INTERNS AND RESIDENTS WANTED

*The * signifies a hospital approved for internships and the + approved for residencies in specialties by the Council on Medical Education and Hospitals of the A. M. A. Consult Council's approved list for types of internships and residencies approved.*

ORTHOPEDICS—APPROVED FELLOWSHIPS OCTO-ber and January; stipend $200. Dr. Guy Caldwell, Alton Ochsner Medical Foundation,+ 3503 Prytania Street, New Orleans 15. D

(Continued on page 66)

The A.C.M.J. MODEL VC-4000 M DIATHERMY UNIT



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Convenient Operation—control panel of maximum simplicity and visibility . . . power outlet connections conveniently located. All-steel cabinet on heavy duty, rubber-tired swivel casters, has compartments at sides for accessories.

Precise Controls—input and output meters and controls, automatic dosage timer and cutoff, and resonance control for maximum energy transfer.

Service with Safety—Model VC-4000 M operates on 105-125 volts, 50-60 cycle A.C., with a maximum line current drain of 12 amperes. Model VC-4000 AM operates on 220-230 volts, 50-60 cycle A.C.

Inspect this diathermy unit at your dealer's, or write for complete information

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The Bright Side

by E. K. H.

"Fluffs" from the Press:

An Alabama paper reports:

"A precious little bungle of love arrived in St. Luke's Hospital for Mr. and Mrs. Gordon Peter, Wednesday morning.

❖

From a Mid West paper—

Mrs. Johnson has entirely recovered from her broken collarbone, but unfortunately her knee is still in the hands of the doctor.

❖

And a West Virginia paper, commenting on the remodeling of a local bridge, noted:

"The bride will remain in place until July 2 under police protection and may be used until that date during daylight hours for visits to the park."

❖

The inventor was showing his insect ray killer to the head of a large insecticide firm. It was a complicated gadget of many tubes, motors and switches. The inventor released a roach from a box. Then, pointing the ray at the bug, he turned a knob, pressed a switch and, presto! the roach was dead. Again he released a roach but, just as he was about to destroy it, the prospective client stuck his foot out and stepped on it.

"Well," shrugged the inventor sourly, "I suppose you can kill them that way, too."

❖

And now it's Jimmy Durante, the poet, who declaims to his audience:

"Say it with flowers,
Say it with sweets,
Say it with artichokes,
Say it with eats.
You can say it with jewelry
Or say it with mink,
But whatever you do,
Never say it with ink!"

A patient called his dentist for an appointment. "So sorry," said the dentist, "not today. I have eighteen cavities to fill." And picking up his golf bag, he hurriedly departed from his office.

Mother, pointing to the famous picture of Pilgrims going to church, told her son, "See? They went to church every Sunday!"

The small boy noticing guns carried by the men, replied, "I'd go every day if I could shoot Indians on the way."

❖

The executive, just returned to his office after a vacation at one of the country's better-known resort hotels at Saratoga, was extolling its virtues to a friend.

"I had two full weeks of exercise, fresh air, golf, wonderful food, and of course the race track. And I must say I came home feeling absolutely fit—not an ounce of superfluous cash on me!"

❖

"It is said," relates Earl Wilson, "that for every man of 83 there are seven women—but by that time it's too late!"

"I'm Trying to Get a Fur Coat. Got Anything That Will Stimulate Real Tears?"

(Continued from page 62)

RESIDENCIES—MEDICAL CHEST DISEASES; JANUARY 1955; 2 openings; 1 position available now on approved 260 bed service in hospital + with complete medical and surgical facilities for treatment of tuberculosis and other chest diseases; active teaching program and encouragement of research; salary $300 with maintenance for couple or $400.00 without maintenance; eligibility for California license essential. Address inquiries to: A. Goldman, M.D., Chief of Professional Services, City of Hope, Duarte, California. D

RESIDENCY IN OPHTHALMOLOGY — ARRIVAL October 1, 1953; 2 year approved residency; active ophthalmology service in a 300 bed general hospital *+ and group clinic; stipend 1st year $125, 2nd year $150. Reply to: A. L. Rhoades, MD., Director, Department of Ophthalmology, Geisinger Memorial Hospital and Foss Clinic, Danville, Pennsylvania. D

PLASTIC SURGERY RESIDENCY — INTEGRATED training program of research and general plastic surgery; approved ACS. and American Board; commencing January 1, 1955; active service in large teaching hospital affiliated with medical school; full maintenance and monthly stipend. Box 7230 D, % AMA.

APPROVED RESIDENCIES IN MEDICINE AND surgery; excellent services; $250-$300 a month with ascending scale, depending on previous training; open only to graduates of approved schools. Lelia Y. Post, Montgomery Hospital, Battle Creek, Michigan. D

WANTED — RESIDENT IN INTERNAL MEDICINE; 3 year program vacancy now; middle west hospital and clinic; adequate stipend. Box 7180 D, % AMA.

OTOLARYNGOLOGY RESIDENCY—AMA. RESIDENCY approved; excellent training in clinic and surgery; stipend and full maintenance. The Harlem Eye and Ear Hospital, + 2000 Lexington Avenue, New York City, 35. D

PSYCHIATRY RESIDENCIES AVAILABLE — IN 700 bed university-teaching general hospital *+; with 60 bed acute treatment psychiatric unit fully approved for 3 years training; experience includes dynamically-oriented psychotherapy with children and adults, shock therapies and neurologic training; salary range $1620-$4000 annually, plus laundry, uniforms and room. Address inquiries to: Medical Director, Albany Hospital, Albany, New York. D

RESIDENCIES IN PSYCHIATRY—DUKE UNIVERSITY *+; 2 year approved; complete patient and research facilities; closely supervised dynamic psychotherapy and somatic therapy; adult and children's OPD; training in psychosomatic medicine and neurology; minimum starting salary $2000, plus room and board, uniforms and other financial aid. Write: Chairman, Department of Psychiatry, Duke University, Durham, North Carolina. D

APPROVED RESIDENCIES IN PHYSICAL MEDICINE and Rehabilitation; available immediately; in teaching hospital *+ affiliated with medical school; $150 monthly stipend with maintenance; Fellowships available for advanced standing. Write: Director, Physical Medicine and Rehabilitation, Metropolitan Hospital, Welfare Island, New York City. D

ASSISTANT RESIDENCY IN INTERNAL MEDICINE—available in 280 bed Ohio hospital *+; 3 year Board approved program; stipend $250 month plus maintenance. Box 7219 D, % AMA.

NEUROLOGY RESIDENCIES AVAILABLE — IN 700 bed university-teaching general hospital *+; salary range $1620-$2220 annually, plus laundry, uniforms and room. Address inquiries to: Medical Director, Albany Hospital, Albany, New York. D

ANESTHESIOLOGY RESIDENCIES—AT UNIVERSITY of Minnesota Hospitals, Minneapolis Veterans Administration Hospitals and associated hospitals; an opening every 4 weeks. Address: Frederick H. Van Bergen, MD., Director of Anesthesiology, University of Minnesota Hospital, Minneapolis, Minnesota. D

APPROVED RESIDENCIES AND INTERNSHIPS—available now; services include surgery, medicine, obstetrics and gynecology, urology and pathology; 225 bed general hospital *+; requirements: graduate of grade A medical school; also, residencies and internships in pediatrics, orthopedics and ENT; salary commensurate with qualifications. For particulars write: Dr. M. G. Hubbard, Administrator, Nashville General Hospital, Nashville 10, Tennessee. D

ANESTHESIOLOGY RESIDENCY — APPROVED FOR 1 or 2 years; for graduates of approved medical schools who have completed 1 year of an approved internship; medical college affiliation. Address inquiries to: Medical Director, Albany Hospital,*+ Albany, New York. D

WANTED — UROLOGICAL INTERN OR RESIDENT; hospital *+ in South-East; salary $100-$175 plus full maintenance; also eligible to apply for Fellowship Fund; service approved by AMA and Board of Urology; good training program affiliated with medical school. Box 7225 D, % AMA.

HENRY FORD HOSPITAL *+—DETROIT, MICHIGAN; pathology residency; Board approved; clinician pathology and pathologic anatomy; 4 years; 450,000 laboratory tests yearly, 400 autopsies, 5000 surgicals; liberal stipend. Apply: Pathologist-in-Chief. D

PSYCHIATRY RESIDENTS—INDIANA UNIVERSITY; 3 year program; psychotherapeutically oriented psychoanalytical psychiatry; individual supervision emphasized; 400 inpatient beds; outstanding clinics, children and psychosomatic services $4500-$4800-$5700. Details from: Dr. Philip Seitz, Indiana University Medical Center, Indianapolis, Indiana. D

GENERAL PRACTICE RESIDENCY—AVAILABLE IMmediately; AMA. approved; also one in February 1955; only graduates of approved medical schools will be considered. Write: MacNeal Memorial Hospital,*+ Berwyn, Illinois. D

PATHOLOGY RESIDENCY—APPROVED FOR TRAINing in pathologic anatomy alone or in conjunction with clinical pathology; available in 400 bed teaching hospital *+; research encouraged and medical school appointments available in 3rd and 4th year. Apply with full details in 1st letter to: Dr. Henry Rappaport, Pathologist, Mount Sinai Hospital, California and 15th St., Chicago. D

TWO INTERNS WANTED IMMEDIATELY—160 BED general hospital * located in southern New England industrial area within 25 miles of 2 large medical centers; recently fully accredited; $150 per month plus maintenance. Apply: W. A. Towle, Jr., Administrator, Bristol Hospital, Bristol, Connecticut. D

WANTED — FIRST YEAR RESIDENT IN GENERAL surgery; in a 3 year approved program; in a middle west hospital and clinic; integrated program and adequate stipend. Box 7160 D, % AMA.

WANTED — RESIDENTS IN PSYCHIATRY; THREE year approved residencies available; large eastern mental hospital *+; excellent teaching program including post graduate university courses; training in modern therapeutic procedures; salary $4400-$5100. Box 7195 D, % AMA.

GENERAL PRACTICE RESIDENCY — SALARY $200 per month and full maintenance; 135 bed hospital with a very active service; near Philadelphia on the main line of the Pennsylvania Railroad. Apply: Miss Helen V. Barton, Coatesville Hospital, Coatesville, Pennsylvania. D

MICHAEL REESE HOSPITAL *+ RESIDENCIES available; dermatology, x-ray and pathology; fully approved program; 650 bed general hospital with outstanding training and research program; stipend and full maintenance provided. Apply: Medical Director, Michael Reese Hospital, Chicago 16, Illinois. D

OBSTETRICAL-GYNECOLOGICAL — SECOND OR 3rd year approved residency available in large general hospital *+ located in medical center of South; salary plus full maintenance. Apply: Administrator, St. Joseph Hospital, Memphis, Tennessee. D

INTERNSHIPS — ROTATING; AVAILABLE IMMEDIately; busy 100 bed general hospital * in suburban area of Detroit; training program well-grounded. Apply: Intern Committee, Bon Secours Hospital, Grosse Pointe 30, Michigan. D

UROLOGICAL RESIDENT — THIRD YEAR OR ONE wishing another year of active service in 225 bed, approved hospital.*+ Write: Director of Urology, Germantown Hospital, Philadelphia 44, Pennsylvania. D

PSYCHIATRIC RESIDENCY—IN AFFILIATION WITH government hospital *+; beginning salary $5,520; citizenship required. Write to: Ralph M. Patterson, Chairman, Department of Psychiatry, Ohio State University, College of Medicine, Columbus, Ohio. D

ANESTHESIOLOGY RESIDENT PROGRAM IS NOW available; at the St. Louis City Hospital,*+ St. Louis, Missouri. Applicants are invited to address inquiries to: the Medical Director. D

RESIDENTS IN PSYCHIATRY—THREE YEAR APproved residencies with organized didactic curriculum and well-balanced clinical assignments; at VA Hospital,+ State Hospital,+ Menninger Hospital + and Outpatient Clinics, all located in Topeka; and affiliated with Topeka Institute for Psychoanalysis. Write: Menninger School of Psychiatry, Topeka, Kansas. D

(Continued on page 68)

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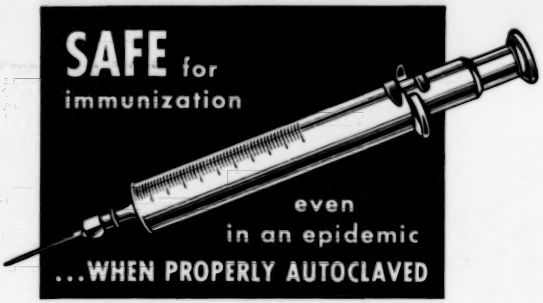

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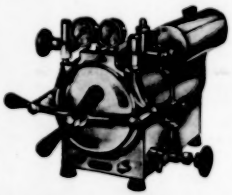

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(Continued from page 66)

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SITUATIONS WANTED

GENERAL PRACTITIONER — 29; PENNSYLVANIA Boards July, 1954; married; category IV; desires association October 1st with general practitioner, or take over established practice; prefer small western Pennsylvania town 15,000 or less. Box 7253 I, % AMA.

POSITION, LOS ANGELES AREA—OCTOBER, NOVEMber, December 1954; 3 years surgical residency, then general practice; experience including obstetrics. Contact: J. P. Huber (Captain (MC), Infirmary, McConnell Air Force Base, Wichita, Kansas. I

INTERNIST—CERTIFIED; 35; CATEGORY IV; DESires association with individual or group California; excellent professional background, all phases internal medicine; 4 years private practice experience. Box 7237 I, % AMA

INTERNAL MEDICINE—30; DESIRES POSITION IN group or association with internist; rural or suburban; family; military completed; permanent location desired; salary $600-$1000. Dr. Woodard, 152-14 84th Drive, Jamaica 2, New York. I

INTERNIST—FOUR YEARS IN INTERNAL MEDIcine and cardiology at university hospital and a large clinic; desires clinic, group, or association Mid-West or West; married; draft ineligible. Box 7241 I, % AMA.

PHYSICIAN—32; VETERAN; FAMILY; GRADUATE Class A school; licensed Ohio, Virginia; experienced industrial medicine and general practice; desires association with group or individual. Box 7243 I, % AMA.

INTERNIST—32; WILL TAKE BOARD EXAMINAtions October 1954; 4 years residency; excellent references; interested in group or association; Mid-West or West; category IV. Box 7255 I, % AMA.

RADIOLOGIST—DIPLOMATE BOTH BOARDS; AGE 35; family; owing military service; available November 1st; desires association with radiologist or clinic group in South, South-West, or West. Box 7257 I, % AMA.

GENERAL PRACTITIONER—32; WOULD LIKE TO become assistant or associate with individual or group in Minneapolis or St. Paul; available October 1954. Box 7250 I, % AMA.

ANESTHESIOLOGIST—BOARD ELIGIBLE; SINGLE; licensed in New York, New Jersey, Connecticut, Ohio; desires suitable association. Box 7249 I, % AMA.

INTERNIST — 32; BOARD CERTIFIED; MARRIED; leaving service; desires association or location in East or Mid-West, preferably New York State. Box 7033 I, % AMA.

RADIOLOGIST — VETERAN; 35; BOTH BOARDS; University training and teaching experience; several papers; desires congenial association preferable teaching, but will consider any opening; South, Mid-West, North-West. Box 7226 I, % AMA.

ASSISTANT DIRECTOR—CHRONIC DISEASE PROgram; physician, BPH.; 30; interested in coordinating medical services; experience in internal medicine, pediatrics, communicable diseases, chronic illness and rehabilitation in teach-up institutions and state-wide programs; locate anywhere. Box 7200 I, % AMA.

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INTERNIST — HEMATOLOGY; 37; BOARD CERTIfied; FACP; available for interesting and challenging opportunity (clinical, academic or other); experience qualifies for clinical activities and/or teaching; research (basic and clinical); organization and management; medical editing and public relations; direction of graduate students and resident training program; in 10th year large mid-western medical college; currently associate professor. Box 7180 I, % AMA.

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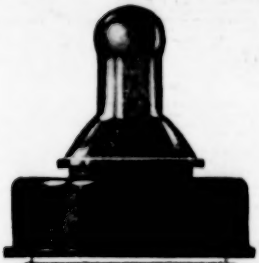

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(Continued from page 68)

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GENERAL SURGEON — 30; BOARD ELIGIBLE; passed Part I; Diplomate national board; family; Navy service completed October; desires association with established individual, group or clinic. Box 7118 I, % AMA.

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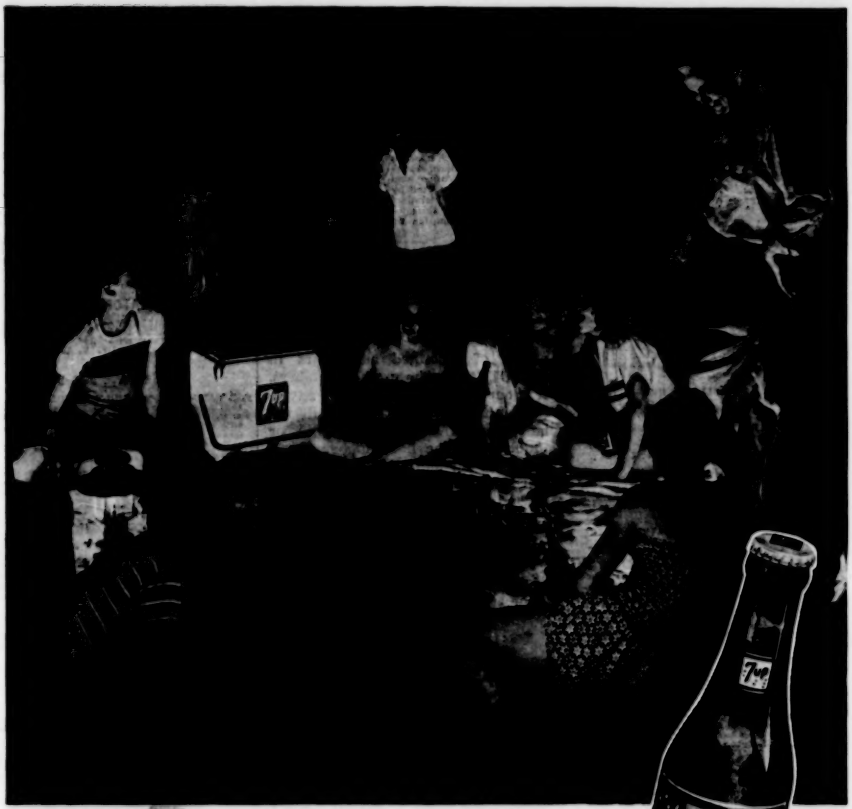

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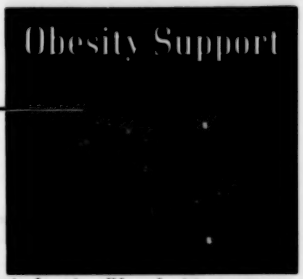

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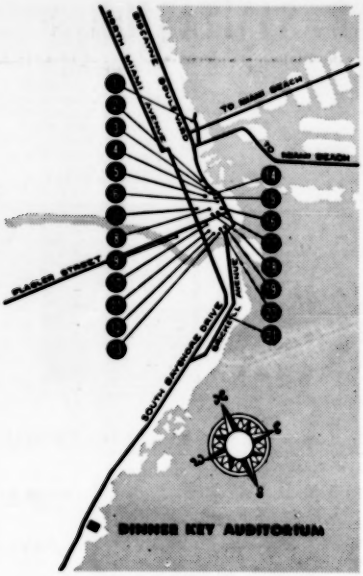

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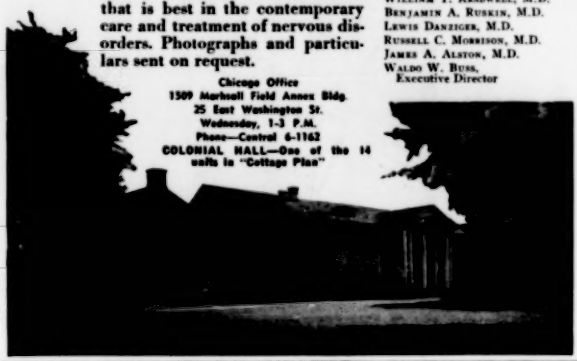

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1. Von Alyea, O. E., and Donnelly, Allan: Arch. Otolaryng., 49:234, Feb., 1949.

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